INTRODUCTION TO PSYCHOANALYSIS

CONTEMPORARY THEORY AND PRACTICE

SECOND EDITION

ANTHONY W. BATEMAN,
JEREMY HOLMES, AND
ELIZABETH ALLISON

ROUTLEDGE

'The best scholarly and clinically focused introduction to psychoanalytic ideas brilliantly integrating and celebrating the majesty of the concepts while also identifying key shortcomings. For a comprehensive, up to date and accessible presentation of this immense body of work you need to look no further'.

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'This book brings together three experts in conveying the essentials of psychoanalysis to varied and often sceptical audiences. They are deeply versed in its framework and clinical relevance, but well able to stand back and ask key questions, including on very contemporary issues such as remote analysis and institutional prejudice. One can hear in their shared voice that they understand, value and respect but do not idealise psychoanalysis. I am sure that a very large number of mental health professionals, trainees and the interested public will be really captivated by the serious, open-minded engagement with what psychoanalysis is and why, helped by the exceptionally clear writing to recognise questions they had not yet formulated but now realise they want to grapple with. I think here they are in safe hands as they navigate the different perspectives'.

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'This splendid second edition has been collaboratively authored by three outstanding clinicians who are superb authors and conceptualizers. They have integrated major themes in psychoanalytic and psychotherapeutic discourse in a seamless way. They have definitely accomplished their goal to bring psychoanalysis into the contemporary scientific and intellectual mainstream and to focus primarily on ideas and techniques rather than personalities. I heartily recommend this impressive second edition to all serious clinicians and to students who are preparing for clinical practice'.

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Introduction to Psychoanalysis

What is psychoanalysis? Is it relevant to today's mental health crisis? How can psychoanalysis help people suffering from psychological distress and illness? This vital new book examines how psychoanalysis has changed since its inception, and how it has adapted to the needs and concerns of 21st-century mental health professionals and patients.

The first part of this book provides a concise and unbiased account of the origins of psychoanalysis, and the theories which characterise the main post-Freudian schools – neo-Freudian, Kleinian, interpersonal, self-psychological, Lacanian – and the ways in which they agree and diverge. The second part uses clinical illustrations to examine the practicalities of psychoanalytic technique in the consulting room – assessment, free association, dream analysis, transference, and counter-transference. Whatever their allegiance or role, mental health professionals – psychologists, psychiatrists, social workers, child mental health professionals, mental health nurses – need to be conversant with the strengths, relevance, and limitations of the psychoanalytic approach.

This book provides an indispensable, up-to-date, and accessible account of psychoanalysis today. Shaped throughout by considering the viewpoint of an interested 21st-century reader, it is of great interest to psychoanalysts and related mental health professionals, as well as students and all those interested in the treatment of mental health.

Anthony W. Bateman is a psychoanalyst whose work on applying psychoanalytic ideas in health service settings led to the development of mentalisation-based treatment for severe personality disorder. He is recognised internationally for his writing and research work and has published widely on mentalisation, borderline personality disorder, and the application of psychotherapy in psychiatry.

Jeremy Holmes is a retired psychiatrist and psychoanalytic psychotherapist. He has published 250+ papers and chapters, and has authored or co-authored 21 books in the fields of attachment theory and psychoanalysis. His most recent books are *Attachment in Therapeutic Practice* (2017) and *The Brain Has a Mind of its Own* (2020).

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Introduction to Psychoanalysis

Contemporary Theory and Practice

Second Edition

Anthony W. Bateman,
Jeremy Holmes, and
Elizabeth Allison

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Preface to the First Edition

Newcomers to psychoanalysis, especially if they wish to avoid confusion, are usually best advised to go straight to Freud – to the lectures on technique (Freud, 1912, 1914), the Introductory Lectures (Freud, 1916–1917), or the Two Encyclopedia Articles (Freud, 1923). This is not just because Freud is the fount from which psychoanalysis has flowed, or because of the clarity of his thought and style, or even because "going back to Freud" remains a psychoanalytic imperative. It is also because in the early years a single psychoanalytic "mastertext" (Schafer, 1990) was still possible, in a way that has not only become increasingly problematic as the psychoanalytic movement has expanded and diversified, but also been challenged by controversy and schism.

There are many excellent introductory or semi-introductory contemporary books about the practice of psychoanalysis. Those that we have found especially useful are starred in the references. Each tends to present a particular perspective on the psychoanalytic process – Kleinian, Independent, Contemporary Freudian, Interpersonal, Kohutian, Lacanian, and Ego Psychological. This is partly an inevitable result of the unique centrality of personal analysis in analytic training. Each of the differing psychoanalytic approaches represents not only a theoretical orientation, but also a tradition, style, affiliation, and set of common values and assumptions that the analysand acquire in the course of this training. He or she has to undergo the maturational task of both assimilating all that has been identified with and at the same time achieving the inner freedom needed to find his or her own analytic voice.

When we were invited by Edwina Wellham of Routledge, at Jonathan Pedder's suggestion, to write a companion volume to his and Dennis Brown's (Brown & Pedder, 1993) *Introduction to Psychotherapy*, we felt that the time was ripe for an attempt to bring together the varying strands of psychoanalytic theory and practice, to highlight their "common ground" (Wallerstein, 1992) as well as their differences. We were encouraged by the idea that despite theoretical divergence, "clinical theory" (Klein, 1976) can be unified in a meaningful way. We were determined to anchor our text with many clinical

examples, and to try to show how a variety of clinical approaches fit within a common framework. We are aware of the dangers and pitfalls of both sectarianism and eclecticism. Analysts need to be able to draw on the range of different ideas and techniques that are encompassed within the diversity of their profession. At the same time, to practice effectively, most need to practice within a particular analytic perspective.

Our book is perhaps in the "critical dictionary" (Hinshelwood, 1989; Rycroft, 1972) tradition in that it tries to clarify, question, and extract what is valuable from each psychoanalytic viewpoint. Wherever possible, we have brought research findings to bear on psychoanalytic concepts and practice, and, within the limitations of the lag between composition and publication, to be as up to date as possible with contemporary psychoanalytic thought. We have subtitled our book "contemporary" psychoanalysis, drawing a useful, but nonetheless somewhat artificial, contrast between "classical" and "modern" (or "contemporary") practice and thought. "Classical" and "modern", while useful as a shorthand, should not be thought of as oppositional, but rather the one resting on the other. Also, since we work simultaneously both within a public sector psychiatric context and in private practice, we have angled a fair proportion of what we discuss towards the role of psychoanalytic therapy with quite disturbed patients.

That raises the issues of who *we*, the authors, are. One of us (A.B.) is an analyst with considerable psychiatric experience, the other (J.H.) also a psychiatrist and psychotherapist with psychoanalytic leanings. We hope that as a team we have enough in common to provide a unified view, enough difference to add breadth to our exposition. On the whole our collaboration has run smoothly. On occasions one of us has felt that we have been too critical and not "analytic" enough; the other that we were being too reverential and have failed to locate the analytic approach within a wider intellectual and cultural context.

And what of *you*, the reader? Our hope was to produce a book that would be useful for students of psychoanalysis and psychoanalytic psychotherapy looking for a single volume that would encompass the main principles and practice of contemporary psychoanalysis, be clinically relevant, and theoretically stimulating. For some, no doubt, much of what we say will be familiar, for others obscure. We hope we have created sufficient transitional space between innocence and sophistication to be of value.

We are only too aware of the many faults of omission and commission in the book. We have tackled the issues of ethnicity, class, and gender in only a very limited way. Our psychoanalytic approach is almost exclusively "Freudian", and we have undoubtedly failed to do justice to the scope of Jungian or Lacanian psychoanalysis. Another notable omission is any serious consideration of child psychoanalysis, which is beyond both our competences. Lacking space rather than enthusiasm, we have failed to follow the important cultural ramifications of psychoanalysis into the fields of literary theory, psychohistory, and sociology.

The text is illustrated with many examples. We are deeply aware of the ethical difficulties in using case material in print. In some instances, we have asked our patients for permission to publish such material. In others, this has not been possible, but we have in every case disguised and fictionalised biographical details.

Books should not necessarily be read from start to finish. Each chapter is complete in itself, and we have used extensive cross referencing between them, since some topics – transference, projective identification, mutative interpretations, and transitional space – inevitably crop up over and over again. There is a dialectic between theory and practice in the learning of any craft or skill, and psychoanalysis is no exception. We are aware of a marked shift of tone between the first, theoretical part, and the second, more clinical and practical part. The first aims to convey an up-to-date account of contemporary psychoanalytic theory, and will, we hope be of interest to advanced practitioners as well as beginners. The second half is inevitably more introductory. This divergence between the sophistication and diversity of theory, and a common strand of practice has become an increasing focus for debate with psychoanalysis (Tuckett, 1994).

A book such as this owes an incalculable debt to the teachers, analysts, colleagues, students, patients, supervisors, and friends (many of whom fall into several of these categories) who have influenced and helped the authors. We would like especially to thank John Adey, Mark Aveline, Rosemarie Bateman, Patrick Galwey, Fiona Gardner, Isabelle Grey, Stephen Grosz, Ros Holmes, Matthew Holmes, Jane Milton, Jonathan Pedder, Rosine Perelberg, Glenn Roberts, Charles Rycroft, and Mark Solms, who have generously and time-consumingly read part or all of the manuscript, and have made many helpful suggestions and corrections. Alison Housley, chief librarian at North Devon District Hospital; Jill Duncan, chief librarian at the Institute of Psychoanalysis; and Eleanor MacKenzie, chief librarian at St Ann's Hospital, Haringey Healthcare, have tolerated our requests for references with amazing cheerfulness and efficiency. Finally, without the love, support, helpful criticism, occasional exasperated protest, and balancing diversion provided by our immediate families, this book could not possibly have come so happily into being.

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Preface to the Second Edition

It came as something of a shock when our excellent editor at Routledge, Susannah Frearson, invited us to undertake a new edition of this book. Was it really a quarter of a century since we compiled our account of psychoanalysis, and how it has shaped our psychiatric and psychotherapeutic practice? But *plus ça change, plus c'est la même chose*, we thought. Given that the wheels of psychoanalysis move slowly – what is new?

Somewhat to our surprise, the answer turned out to be quite a lot – both for us parochially, and more widely. A.B. has devised and spearheaded psychoanalytically informed mentalisation-based treatment (MBT), which is now a leading worldwide therapy for borderline personality disorder, antisocial personality disorder, substance abuse, psychosis, and eating disorders. MBT represents applied psychoanalysis at its best, evidence based from inception, and meeting the gold standard of randomised trials which psychoanalysis had hitherto evaded or eschewed. Meanwhile, J.H.'s interest in attachment theory and more recently relational neuroscience have helped to overcome initial psychoanalytic resistance, moving both towards the psychoanalytic mainstream.

Psychoanalysis tends to be something of a gerontocracy. We are delighted therefore to have a new co-author, E.A., who brings youth, freshness, and a background in English literature, and her experience of running a university-based psychoanalytic training. The latter reflects another innovation in that university-based courses are markedly different from the stand-alone and often cultish trainings that held sway when the first edition was written.

Govrin (2019) makes a useful distinction between what he calls "first-order" and "second-order" creativities in psychoanalysis. The former are elaborations of concepts and techniques pioneered by Freud and his contemporaries, which have been built on and extended by his successors. Among the examples that we describe in this new edition are how the contemporary concept of projective identification emerged from Klein, Bion, and Heimann's reformulations of Freud's concept of countertransference, and have been carried further by Ogden, Birkstead-Breen, and Ferro; how Klein and Winnicott, and later Steiner and Britton, extrapolated back from Freud's Oedipal constellation to

the primal mother–baby relationship; and how Barratt's reworking of Freud's discovery of free association draws on Bollas and Lacan. Second-order innovations are advances and discoveries that are external to psychoanalysis but impact significantly on its theory and practice. These would include observational studies of mother–baby interactions; the demonstrable long-term effects of childhood adversity on mental and physical health; advances in neuroscience; and changing attitudes to gender, ethnicity, and sexual orientation.

Our aim in this second edition is to incorporate these innovations, advances, and extensions, while remaining true to our core aim of presenting psychoanalytic concepts and techniques in a clear and comprehensible way. While every chapter has been extensively rewritten, and references updated, we have stuck with the original structure of the book, except for the addition of a new final chapter, which, we hope, brings the text up to date with the 21st-century context, including a discussion of social media and distance therapy and learning.

After some discussion, we decided to preserve the psychoanalytic "family tree", which forms the frontispiece to the book, although we have not updated it, for fear of inaccuracy, causing offence, or breaking confidentiality. In addition, our aims are to bring psychoanalysis into the contemporary scientific and intellectual mainstream and to focus primarily on ideas and techniques rather than personalities and guru-figures. But there is undoubtedly what Balint (1952) called an "apostolic succession" in psychoanalysis, in which the "succession" of analysts, starting with Freud, represents the equivalent of laying on of hands in the Catholic church. This oral tradition should not be dismissed, in that it embodies (literally) the analyst–analysand relationship, which forms the core of the psychoanalytic method. From a psychoanalytic perspective, personality, developmental history, and espoused ideas are inextricably linked. Practitioners like to know which tradition – Kleinian, contemporary Freudian, relational, self-psychological, etc. – a particular analyst belongs to and thus who their analyst(s) have been. This is not only a matter of gossip – although, admittedly, that plays a big part in analytic life – but also helps to contextualise a colleague's ideas and methods, signposting "where they are coming from".

We stress that this has been an entirely collaborative project. After the first edition appeared, one of us (A.B.) was asked by a purist colleague, wanting perhaps, as some psychoanalysts are wont, to drive a wedge between psychoanalysis and other "lesser" forms of therapy, which chapters he as a fully trained psychoanalyst had written. The loyal riposte was that we were *both* responsible for every word in the book. We would like to think the same is true for all three of us here.

Underpinning both this and the first edition is a fundamental question, which we take up in more detail in the next chapter. Does psychoanalysis still matter? Is our enthusiasm merely a residue of nostalgia and loyalty to a meta-narrative that has shaped us, but is no longer relevant to contemporary

mental health practice and the wider vicissitudes of 21st-century life? Classical psychoanalysis has all but disappeared from the psychiatric and clinical psychology curricula and is almost nowhere to be found in publicly funded psychological therapies. For the uninitiated, the term "psychotherapy" now more or less equates to cognitive-behavioural therapy. Various forms of "wellness" and positive psychology programmes are also very popular.

By contrast, however, there has been a flowering of interest in psychoanalytic ideas in the wider fields of literature, social anthropology, and gender studies. As mentioned, applied psychoanalysis has much to offer in mental health contexts, especially with more disturbed people, and where long-term therapies are needed. But more generally, we see psychoanalysis as the standard-bearer for what in Jungian terms is the "shadow" side of human existence: the disruptiveness of desire, and the inescapability of "deathfulness" (Barratt, 2019), and how these are variously projected, disowned, suppressed, and avoided. In a contemporary Western world, where instrumentalism, surface-living, and visibility dominate, psychoanalysis provides an indispensable language for the contours of an inner world, the uniqueness of an individual life, and fostering a strengthened sense of freedom and resilience.

Finally, sadly, some of those mentioned as inspirations in the first edition are no longer alive. These include two of our mentors, Jonathan Pedder and Charles Rycroft. But others have also swung into our orbit. We would like to thank our friends, family, and colleagues who have helped us to hone our ideas and tolerated the irritations of living with author spouses and parents, but generally spurred us on. For J.H., they include, in no particular order, Kristin White, Evrinomy Avdi, Arietta Slade, Alessandro Talia, Joan Raphael-Leff, Mary Hepworth, Peter Fonagy, Andrew Elder, Tobias Nolte, Sebastian Kraemer, Nick Sarra, Richard Mizen, Josh Holmes, Jacob Holmes, and, as ever, Ros Holmes; for A.B., they include Rosemarie Healy/Bateman who patiently listens to or ignores my growing pains about writing a book without complaint, Alexandra Bateman who is the sharpest of critics, Peter Fonagy for his encyclopaedic knowledge, which he so willingly shares, the late John Gunderson for our long friendship and our close working relationship on the promotion of psychoanalysis and psychiatry, and colleagues and friends who have questioned me over the years; for L.A. they include Peter Fonagy, Mary Hepworth, and David Tuckett, who have supported me to develop my interest in psychoanalysis for over 20 years, Kerry Sulkowicz, whose passion for psychoanalysis has renewed my own, and numerous colleagues in the British Psychoanalytic Society, the Comparative Clinical Methods group led originally by David Tuckett and more recently by Olivier Bonard, and the Psychoanalysis Unit at UCL.

Anthony Bateman
Jeremy Holmes
Elizabeth Allison

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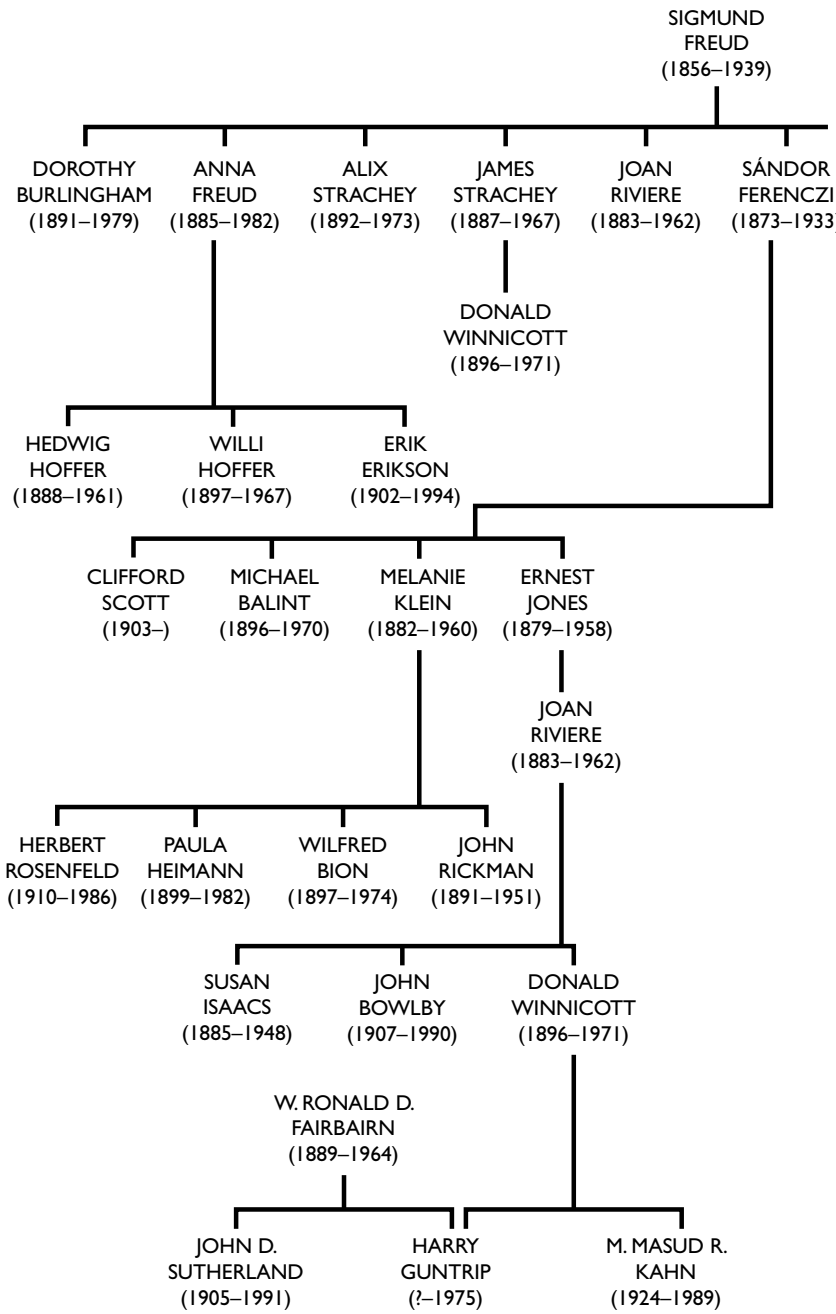
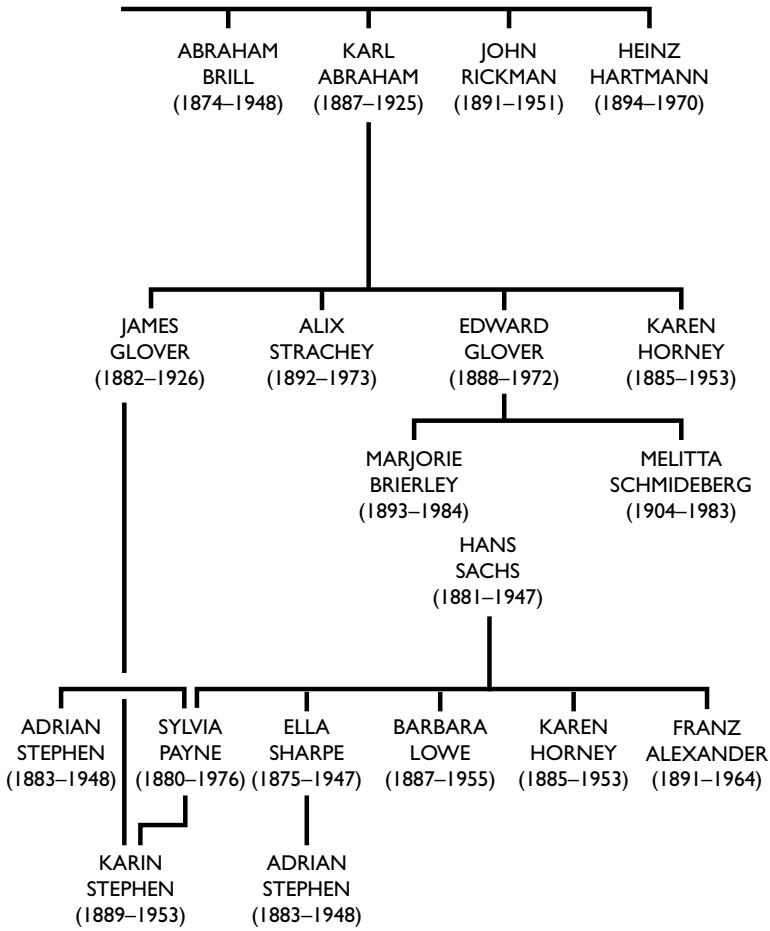


Figure 0.1 Who analysed whom: the transmission of psychoanalytic culture.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Part I

Theory

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Chapter 1

Introduction: history and controversy

> The best way of understanding psycho-analysis is still by tracing its origin and development. (Freud, 1923b, p. 235)

Introduction

Let us start with some of the questions this book tries to address. What is psychoanalysis, does it matter, and if so, why? Is psychoanalysis a 21st-century-relevant concern, or a historical curiosity now superseded by more efficient, evidence-based ways of thinking about mental life and about how suffering can best be alleviated? Is it not an elitist backwater, requiring its participants to be able to afford to spend 3–5 hours per week reflecting on their inner lives and paying for the privilege? Does it open up the possibility of radical reassessment and transformation of how we live our lives, or does the time and intensity of reflection required of the analysand actually militate against change? Is psychoanalysis not guilty of uncritically reproducing and universalising historically and culturally specific – and now long-outdated – assumptions about, for example, sexuality, gender, and the division of labour? Is it not trapped in outdated 19th-century ideas about instincts? Does the psychoanalytic focus on structural change increase the likelihood of the results of treatment enduring, or does its apparent lack of interest in directly alleviating symptoms not show a cavalier disregard for patients' suffering?

These are just a few of the questions typically asked about psychoanalysis today, pointing to its continuing capacity to provoke lively debate well over 100 years after its birth in an obscure private neurology practice in *fin-de-siècle* Vienna. Notwithstanding fairly regular declarations that Freud is dead, there is plenty of evidence that the ideas that he gave birth to, and others subsequently developed, are very much alive. To take just one example, in 2012, when the Maudsley Hospital in London, the premier psychiatric research institution in the world, organised a public debate on the motion "This house believes that psychoanalysis has a valuable place in modern mental health services", it was attended by 350 people – and as

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many more had to be turned away. The expectation in this bastion of biological psychiatry was that the speakers against the motion would carry the day, but the final vote was overwhelmingly in favour of psychoanalysis. Setting aside the question of the outcome of the debate, it illustrates that feelings about psychoanalysis continue to run high.

At times, discussions of the nature of psychoanalysis have a distinct flavour of the blind men feeling the elephant. By "psychoanalysis" we can mean a body of theoretical ideas, a set of therapeutic practices or principles of practice, a quasi-ideological movement, or an institution. The way psychoanalysis is perceived affects the conclusions reached. If we consider the use of the couch and a frequency of four or five sessions per week to be essential to the definition of psychoanalysis, this may limit our capacity to consider the potential value of both its clinical and non-clinical applications. If we maintain that in the absence of transference interpretation what transpires in the consulting room cannot be psychoanalysis, this will have a significant impact on our ideas about who is likely to benefit from it. If we insist that any psychoanalysis worthy of the name must concern itself with the fate of the patient's infantile sexuality, this will give the treatment quite a different flavour to an approach focused on the development of a sense of self as one separates from one's primary caregiver; and so on. There is a lack of consensus about both the common theoretical ground and the definition of psychoanalytic – as distinct from other forms of psychotherapeutic – practice, and intense disagreements about which institutions have the authority to decide what does or does not constitute psychoanalysis.

Despite this squabbling, much of which is fuelled by what Freud (1918, p. 199) aptly called "the narcissism of minor differences", there continues to be an eager appetite among other academic and therapeutic disciplines such as literature, anthropology, sociology, and linguistics for psychoanalytic perspectives, and interest in psychoanalysis is growing in areas of the world where it has not traditionally had much of a foothold, such as in China, where there is increasing demand for psychoanalytic training and supervision. Recent phenomena such as the reckless investing behaviour that led to the financial crisis of 2008, the rise of nationalism and various forms of political extremism, the alarming growth of hate speech, misogyny, racism, and xenophobia, and the wide range of emotional reactions to the impact of the Covid-19 pandemic, have revealed the limitations of models of human behaviour based on the assumption that human beings are rational animals. Developments in neuroscience have opened up the possibility of a rapprochement of Freudian ideas with the discipline from which they originally sprang.

One of the deepest and most foundational psychoanalytic insights is that conflict structures the human mind. Freud believed that resistance to psychoanalysis was inevitable because psychoanalysis shines a light on those aspects of ourselves that we would rather not know about or share with

others. As he listened to the patients who visited his neurology practice, and thought about their symptoms and dreams – both theirs and his own – he became more and more convinced that our thinking is influenced by processes of which we are not consciously aware, that we are actively invested in remaining unaware of these processes, and that we will resist efforts to make us aware, even if we agree in theory that knowing more about what shapes and motivates us might be a good thing. These two insights – the conflictual nature of the human psyche and the role of the unconscious – remain as valid and, we would say, relevant today as when Freud first formulated them.

Freud saw psychic conflict as the enduring legacy of our helplessness and dependency in infancy. Humans are an altricial species – that is, infants are completely dependent on their caregivers for a long period of time. Once we are able to fend for ourselves, we tend to want to forget the time when we were not able to, and yet we are indelibly marked by it. The experiences we have with our primary caregivers are shaped by our temperament and genetic makeup (i.e., Freud's "constitution") as well as by our caregivers' responses. This intense interpersonal biobehavioural matrix of infancy and early childhood forms templates – which are more or less modifiable – for future relationships and being in the world. Our struggle as young children to understand and come to terms with our complicated feelings about our earliest love objects and our place in the family lays the foundations of enduring psychic structures that will determine the characteristics of our later attachment relationships. Here, again, current trends are favourable to an increased receptiveness to psychoanalytic perspectives, with growing recognition of the developmental nature of mental health problems. Longitudinal research has shown that three-quarters of mental health problems can be traced back, in an additive way, to "adverse childhood events" (Kim-Cohen et al., 2003).

In infancy, we were dependent on our caregivers as attachment figures to help manage the physical and emotional needs we were not yet equipped to cope with. The psychological processes revealed by psychoanalysis apply equally to adult life. For example, we may attribute the feelings in ourselves that we would rather not know about to some other person (projection) and then attack the other person for supposedly having them. As well as being useful in helping to make sense of what happens psychoanalytically, ideas like these are often helpful for mental health professionals struggling with bewilderingly difficult feelings about their work, even if the therapeutic technique they are using is not technically psychoanalytic. Other modalities, such as cognitive-behavioural therapy, are beginning to use some of the theoretical and clinical features of the psychoanalytic approach.

In sum, there is plenty of evidence that the psychoanalytic perspective continues to be valued and that the current climate of opinion is, if anything, more favourable to what psychoanalysis may uniquely have to offer than it was when the first edition of this book was published. Our aim in this second edition remains to present the core features of contemporary psychoanalytic

theory and practice, a bedrock that might then form the basis for a wider discussion about the nature and role of psychoanalysis within psychiatry, psychotherapy, and society. In this introductory chapter, we will review some of the key issues of debate and controversy that currently preoccupy psychoanalysis. To put these discussions into context, as well as being a backdrop to the whole book, we start with a brief account of the history and evolution of the psychoanalytic movement.

History of the psychoanalytic movement

Freud liked to compare the adult personality with an archaeological site, comprising layer upon layer of civilisation, each based on and retaining some features of the one it replaced. Thus, he saw the ego as a "precipitate of abandoned object cathexes" (Freud, 1923a, p. 29), constructed from the important figures from the past with whom each individual has identified. Both metaphors could be applied to psychoanalysis itself, which, if approached historically, reveals how new ideas often emerge from but do not entirely replace previous ones, and where the personality of a thinker is sometimes as important as the content of his or her contribution. The story of psychoanalysis is a mixture of history, geography, and charismatic influence.

Psychoanalysis comprises three interrelated strands: a set of specific psychotherapeutic techniques such as free association and interpretation; a model of psychological development; and a "metapsychology", speculative hypotheses about the nature and structure of the mind. Freud (1914b, 1927) described several phases in the evolution of psychoanalysis.

1885–1897: the "pre-analytic" phase

In this book, we approach psychoanalysis as primarily a craft. It is consistent with this viewpoint that Freud was first propelled towards the invention of his "new science" for quite mundane and practical reasons. In 1886, at the age of 30, Freud got married. He realised that he would need to provide for his wife and what was within a few years to become a large and growing family. Although he was already well known as a distinguished neurologist and neuroanatomist, the opportunities either for advancement in a university rife with antisemitism, or for private neurological practice, were limited. Freud was aware of the many patients with hysterical symptoms and what he was later to call "psychoneurotic disorders" who thronged physicians' consulting rooms. He had visited Paris and been impressed by Jean-Martin Charcot's demonstration of the extent of hysterical phenomena, and by accounts of Pierre Janet's successful hypnotic treatment of hysteria. He, therefore, determined to build his practice around the treatment of these patients.

Here, he was helped by one of the several important friendships that contributed to the gestation and birth of psychoanalysis. Freud's friend Josef Breuer, a general practitioner, had been experimenting with the use of hypnosis in the treatment of a young girl (the famous "Anna O") suffering from paralyses and episodes of mental confusion. Breuer had found that by putting her into a hypnotic trance and asking her to speak freely about whatever was troubling her, the symptoms were temporarily relieved. Freud began to work with Breuer, a collaboration that they wrote up as *Studies in Hysteria* (Breuer & Freud, 1893–1895), based on 13 such cases. Their "cathartic" approach centred on the idea that neuroses resulted from the "damming up" of painful affect and that, like the lancing of a boil, if mental distress could be released via its verbal expression under hypnosis (known as abreaction), relief would follow.

At this point, we encounter one of the features of Freud's character that has shaped the course of the history of psychoanalysis: his capacity to confront and theorise about a difficulty (or "resistance") and turn it to advantage. He came up against a number of problems with hypnosis. First, he found that there were patients whom he was unable to hypnotise. Second, he began to be suspicious of the idea of hypnotic "suggestion", feeling that it overemphasised the role of the physician and compromised the patient's autonomy. Third, he observed at first hand the phenomenon of transference when Breuer's patient, on waking from a trance, flung her arms passionately around her physician. Finally, searching for a traumatic explanation for the patients' difficulties, he discovered, or thought that he had discovered, that they sprang from sexual trauma in childhood – a view that was repellent to the more prudish and timorous Breuer.

1897–1908: psychoanalysis proper; Freud's wilderness years

The next few years were a period of intellectual ferment and emotional crisis for Freud, during which, with the help of his friend Wilhelm Fleiss, with whom he maintained an intense correspondence, he established the practical and theoretical foundations of psychoanalysis, which have lasted to this day.

He abandoned hypnosis and devised the method of free association, which was aided at first by light pressure of the analyst's hand on the patient's forehead. He began to see neurosis not simply in terms of actual trauma, although this still played a part, nor, as Janet had believed, as the result of "weakness" of the nervous system, but as the result of unconscious *conflict*. At the core of this conflict were instinct-driven *phantasies*, the "ph" spelling indicating the unconscious nature of the mental content, concerning sexuality: the male child's oedipal wish to possess his mother, in conflict with the fear of his father's possessive retribution. The *Three Essays on Sexuality* (Freud, 1905) emphasised the central importance of infantile sexuality and

the role of bodily experience in the early development of the personality, which has become one of the pillars of psychoanalytic thinking.

Freud's move from "seduction theory" to the idea of unconscious phantasy has provoked huge controversy among historians, especially in the light of contemporary knowledge of the extent of childhood sexual abuse. The ideas of wish-fulfilment and phantasy are central to psychoanalysis. Freud came to the conclusion that his patients' accounts of seductions reflected the wish-based, pleasure-principle-driven nature of the inner world, and this was a vital step forward. Nevertheless, he also continued to acknowledge the role of outer reality: "seduction during childhood retained a certain share, though a humbler one, in the aetiology of neuroses" (Freud, 1925, p. 34).

Implicit in conflict was *resistance* to the analyst's attempts to penetrate the defensive structures of neurosis, as a first step towards change. Freud initially saw transference – epitomised by Breuer's patient's passionate embrace – as a resistance, impeding the smooth flow of free association. But, as he came to realise that such phantasies were an *in vivo* re-enactment of the patient's core difficulties, transference became the centrepiece of the psychoanalytic method. The culmination of this period was *The Interpretation of Dreams* (Freud, 1900), which Freud always considered his finest work. Here, he drew on his own personal struggles – sibling rivalry, ambivalent reactions to his father's death in 1896, the sense of being his mother's favourite, pride and humiliation in his Jewishness, and professional isolation and ambition – to develop a theory not just of dreams but of the mind itself.

1907/1908–1920: the beginnings of the psychoanalytic movement

As the first decade of the 20th century progressed, so Freud's ideas began to take hold among a group of progressive physicians and intellectuals, who became the first psychoanalytic circle: Carl Jung, Alfred Adler, Wilhelm Stekel, Karl Abraham, Sandor Ferenczi, Ernest Jones, and Otto Rank – the original "ring bearers" for whom Freud had special rings made, as he did for all his favoured disciples. In 1908, the first psychoanalytic congress was held in Salzburg and a journal was inaugurated. Jung, the first non-Jew to join the ranks of psychoanalysis, soon became Freud's "crown prince", and with the influential Eugene Bleuler, his chief at the Burghölzli psychiatric hospital in Zürich, formed a psychoanalytic nucleus in Switzerland. Freud and Jung were invited to the United States in 1910, where Freud gave the prestigious Clark lectures. The two men diverted themselves on the Atlantic crossing by analysing each other's dreams. Perhaps this intimacy was too much: by 1913, Jung had split from Freud, protesting about Freud's insistence on the centrality of sex, his suspicion of religion, and his authoritarian methods. Adler, too, had left in 1911 to set up his own school of psychotherapy, which emphasised aggression and the "inferiority complex", rather than Freud's libido and Oedipus, as central determinants of character.

Jung and Adler's defections were by no means the last that psychoanalysis was to see (Stekel had also left in 1911), but the psychoanalytic movement continued to grow, with clinics established in Budapest, Berlin, and London, the latter thanks to Ernest Jones's combination of energy, intellectual gifts, and absolute devotion to Freud.

The 1914–1918 war had a major impact on the evolution of psychoanalysis in Europe. Freud, now aged 60, his fame fully established, continued to work prodigiously, producing the great metapsychological papers *On Narcissism* (Freud, 1914a) and *Mourning and Melancholia* (Freud, 1917b), as well as the *Introductory Lectures* (Freud, 1916) (delivered, by established psychoanalytic tradition, extempore) during this period. The carnage of the First World War turned his thoughts to the darker side of human psychology, and Freud began to emphasise aggression more than before, ideas that would culminate in the 1920s with the notion of *thanatos*, the death instinct.

In Britain, the "Great War" had a positive impact on the spread of psychoanalytic methods and ideas. Large numbers of soldiers returned from the front with battle fatigue or shell shock (forerunners of the contemporary diagnosis of post-traumatic stress disorder). Conventional psychiatry at that time had little to offer, leaving the way open for psychoanalytic methods at centres such as the Brunswick Square clinic in London headed by James Glover, which became a breeding ground for British psychoanalysis, employing James's brother Edward Glover, Sylvia Payne, Ella Sharpe, Susan Isaacs, and Marjorie Brierley, all later to become prominent psychoanalysts. The Cassel hospital in Richmond, just outside London, was founded in the immediate aftermath of the war as an inpatient unit for psychoanalytic treatment of war casualties.

1920 to Freud's death in 1939

Freud's powers as a theoretician remained undiminished to the end of his life. The year 1923 saw the publication of *The Ego and the Id* (Freud, 1923a), his major revision of the "topographical" model (which had divided the mind into the unconscious, preconscious, and conscious parts), proposing instead the "structural" or tripartite model of id, ego, and superego (see Chapter 2). In 1926, he produced a revised theory of anxiety, which he now saw as signalling a threat to the self, rather than being a manifestation of surplus erotic energy or *libido*. A short but highly influential paper on fetishism (Freud, 1927) introduced the idea of splitting of the ego, which remains central to contemporary psychoanalysis. Throughout the 1930s, Freud continued with his speculations about religion, as well as struggling with ideas about female sexuality, stimulated no doubt by the increasing numbers of distinguished female analysts.

Freud's daughter Anna pioneered the psychoanalytic treatment of children and, after her mother's death, cared for her father – Antigone to his Oedipus. When the Nazis arrived in Austria in 1938, Freud was allowed to leave for England, whence many analysts had already fled. Before they would release him, the Gestapo insisted that Freud sign a document saying that he had been well treated by them – he wrote, with characteristic irony, "I can heartily recommend the Gestapo to anyone" (Jones, 1957, p. 226)! With Anna, he settled at Maresfield Gardens in Hampstead, North London. He died a year later in 1939, just before the outbreak of the Second World War.

Psychoanalysis in Britain

The politics of the psychoanalytic movement has been characterised from the start by a tension between the need to defend the faith – including the expulsion of heretics if necessary – and the wish to extend its boundaries and accommodate new ideas. Psychoanalytic ideas had an important impact on intellectual life in Britain in the 1920s, influencing progressive psychiatrists and medical practitioners as well as members of the Bloomsbury Group, among whom Karin Stephen and James Strachey began medical training specifically to become psychoanalysts (Pines, 1991). Ernest Jones was determined to preserve psychoanalytic identity from dilution by psychotherapeutic fellow travellers and hangers-on. However, unlike his American counterparts, he was generally in favour of recognition and equal status for "lay" (i.e., non-medically qualified) analysts, for which he had Freud's full support (Freud, 1926). When Alix and James Strachey organised a British lecture tour for the young Berlin-based psychoanalyst Melanie Klein, Jones took to her at once and invited her to settle in London, as well as arranging for his children to be analysed by her. Unattached – she was a divorced woman whose children were nearly grown up – she accepted, a fateful move for the history of psychoanalysis.

Klein, who had been analysed by Ferenczi and Abraham, had devised a method of play therapy derived from dream interpretation, which she claimed enabled her to understand the minds of infants and small children. As her work developed, she applied these findings to analytic work with disturbed adult patients, focusing on the mother–infant relationship, and claiming that oedipal conflicts could be found in the first year of life – much earlier than Freud had thought. Later, especially after the death of her beloved son Hans in a climbing accident (Grosskurth, 1986), she emphasised the role of aggression and envy in infantile life, and extended her own analyst Abraham's classification of developmental stages with the idea of an early "paranoid–schizoid position", to be superseded in the mature child by the "depressive position" (see Chapter 2).

Freud was suspicious of Klein, especially as her ideas conflicted with those of his daughter Anna, also a child psychoanalyst, who doubted the validity of Klein's speculations about the mental life of infants, and felt that a more supportive technique was needed in treating children. As refugee psychoanalysts started to arrive in London in the 1930s, tension built up between the Viennese immigrants and the followers of Klein, who included Joan Riviere, John Rickman, Susan Isaacs and, as students, Donald Winnicott, Wilfred Bion, and John Bowlby. After Freud's death, rivalries heightened, and by 1944 two distinct camps had emerged, clustered around Klein and Anna Freud. The atmosphere was electric and there was grave danger of the British Psychoanalytical Society splitting apart. A series of talks was organised, the "controversial discussions" (King & Steiner, 1991), and a compromise emerged, the "gentlemen's agreement" (in fact arranged by three women: Klein, Anna Freud, and the mediator Sylvia Payne). This established two separate groups within the Society, roughly corresponding to the Kleinians and Anna Freudians, each with its own training programme and quotas on committees. Later, a third group, the Independents or "middle group", emerged. It remains debatable whether this "broad church" arrangement represented a triumph for British common sense and pragmatism, or a feeble compromise that impeded the growth of independent and original ideas within psychoanalysis.

Nevertheless, there followed a period of great creativity within the British Society. Klein became a dominant figure, and her ideas were extended by Bion, Hannah Segal, Winnicott, Herbert Rosenfeld, Betty Joseph, and others. This British "Object Relations" perspective was a significant move away from Freud's drive-based developmental schema to one in which the infant–mother relationship was of central importance. It drew partly on Kleinian ideas of an inner world populated by representations of early childhood relationships distorted by phantasy, and partly on the work of Independents such as Michael Balint, who postulated a primary relatedness distinct from the drives for food and sex. Bion and Winnicott, in very different ways, emphasised the role of the maternal environment, or "breast", in providing favourable or unfavourable conditions for psychological growth and integration. Although Bowlby was himself gradually estranged from the Society, his linking of ethology with psychoanalysis provided scientific support for Object Relations ideas. Ronald Fairbairn, despite working in self-imposed isolation in Edinburgh, was also an important contributor, as was his pupil John Sutherland, who became the first post-war director of the Tavistock Clinic in London.

The three groupings remain a key feature of the contemporary British Society, but, as we shall see, they have become somewhat less rigid, with some overlap and cross-fertilisation. Differences do not always harden into ideological positions to be defended almost to the death, but rather appear as variations in style and emphasis. For example, among the "contemporary

Freudians", Joseph Sandler and colleagues (Sandler, Dare, & Holder, 1972) helped to clarify key psychoanalytic concepts. In their distinction between the "present unconscious" (i.e., that which is currently active in the analytic situation) and the past unconscious, they have revived the "topographical model" (Sandler & Sandler, 1984, 1987, 1994). Peter Fonagy and colleagues (Fonagy, Gergely, & Target, 2007) vigorously applied experimental methods to problems of child development. Among prominent Kleinian authors, Elizabeth Spillius (1994), Segal (1986, 1991), Joseph (1989), and Robert Hinshelwood (1989; Hinshelwood and Fortuna, 2018) have carefully clarified the meanings and clinical implications of Kleinian concepts. John Steiner (1993) has consolidated the Kleinian approach to borderline conditions based on projective identification. From the Independent group, Neville Symington (1986) and Nina Coltart (1993) have written useful and highly individual introductory texts, while Gregorio Kohon (1986) and Eric Rayner (1991) have brought together the key thinkers in the group. Patrick Casement (1985, 1990) and Christopher Bollas (1989, 1992, 2009) have in different ways extended Winnicott's ideas about transitional phenomena and countertransference in exquisitely detailed accounts of the interpersonal context of the psychoanalytic relationship.

Psychoanalysis in the Americas

In 1925, 22% of the members of the International Psychoanalytic Association were from North America. By 1952, the figure had risen to 64%, mainly because of emigration from Europe but also because of the fertile soil for new ideas typical of the United States. In contrast to its marginal impact on the medical profession in Britain, psychoanalysis became a dominant force within American psychiatry in the 1950s and 1960s. The pre-eminent paradigm was Heinz Hartmann's (1939) ego psychology, which emphasised the adaptive function of the ego, and its capacity for creating a "conflict-free zone" in contrast to the *Sturm und Drang* of Freud's seething cauldron of the unconscious. Just as immigrants often retain traditional features of their parent culture more fervently than those who live in their country of birth do, so North American psychoanalysis was far more conservative than its European counterparts. Drive theory and the structural model (see Chapter 2) reigned supreme. Non-medical analysts were excluded from the American Psychoanalytic Association – a ruling that persisted until the late 1980s when, following a challenge through the courts from a psychologist claiming unfair discrimination, members of other professions were finally admitted as candidates.

The sheer size of the United States, with many separately operating psychoanalytic groupings, led to a profusion of ideas and approaches. Erik Erikson's (1963) eight-stage developmental schema, emphasising cultural as well as intrapsychic factors, has been very influential (see Chapter 3). Margaret Mahler (Mahler, Pine, & Bergman, 1975) used direct observations of children in her

account of psychological development, later to be modified and put on a more strictly scientific basis by Donald Stern (1985) and Robert Emde (1981). Erich Fromm (1973), one of the so-called "neo-Freudians", discussed the political role of psychoanalysis in society, laying the foundations for Lasch's (1979) later critique of cultural narcissism. Karen Horney (1939) was one of the pioneers of the feminist response to psychoanalysis, built on by Nancy Chodorow (1989) and Jessica Benjamin (1988). Harry Stack Sullivan (1953) founded the Interpersonal school, which has many similarities to British Object Relations, emphasising relatedness and the here-and-now, in contrast to "classical" therapy based on identification of repressed sexual and aggressive drives and reconstruction of a putative past. His theories were influential in the work at Chestnut Lodge in Rockville, Maryland, where Frieda Fromm-Reichmann (1959) and Harold Searles (1965) also used a Winnicottian "holding" model, and emphasised the importance of countertransference in the treatment of severely ill and borderline patients. Mitchell and colleagues (Greenberg & Mitchell, 1983; Mitchell, 1988) developed the interpersonal perspective, showing how it relates to Berlin's notion of "positive liberty" – freedom *to* develop one's potential, in contrast to the classical drive-based "negative liberty", or freedom *from* conflict and external interference. Interpersonal psychoanalysis (Aron & Leichich, 2011) is in some ways a radical departure. It sees the psychoanalytic relationship as a co-created matrix that is contributed to by both patient and analyst. It incorporates perspectives from feminism and anti-discrimination, whether on the grounds of gender, sexual orientation, or ethnicity, and analyses their impact on the analytic process. However, applying the "fly on the analytic wall" test – would such an insect be able to tell whether the therapy in progress was Kleinian, neo-Freudian, self-psychological, or interpersonal? – the practice of interpersonal psychoanalysis follows mostly traditional lines, with the controversial exception that the analyst tends to be more self-revelatory than his or her non-interpersonal counterparts.

A significant challenge to American "classical" psychoanalysis was Heinz Kohut's (1977) self-psychology, which emphasises deficit rather than conflict as being at the core of many modern ills, sees healthy narcissism as the foundation of good object relations rather than their antithesis, and highlights empathy and attunement rather than interpretation and insight as the curative factors in successful treatment. Self-psychology struck a chord in the psychological world, and fierce debate took place as to whether this was "true" psychoanalysis. In defence of his active empathic method, which he contrasted (possibly in a straw-man way) with the impassivity and silence of the classical analyst, Kohut made the sociological point that Freud's original patients were victims of enmeshed and intrusive family situations, and needed an unintrusive analyst if they were to find their autonomy, whereas today's patients are products of parental neglect and family breakdown, and so need to feel actively held and valued if analysis is to help.

Another challenge to mainstream psychoanalysis in the United States has come from a group of authors, many of them pupils of David Rapaport

(1951a), who questioned the Freudian metapsychological superstructure, calling for a "theorectomy" (Klein, 1976), which would leave behind a healthy set of *clinical* ideas and techniques (Wallerstein, 1992). In a related vein, Schafer (1976) and Spence (1982) picked up on ideas from hermeneutics that psychoanalysis is best seen as a linguistic or hermeneutic discipline rather than a strictly scientific one, concerned more with meaning than mechanism, an approach that also arose independently in Britain though the work of Home (1966) and Rycroft (1985). A contemporary proponent of this critique is Barratt (2013, 2016, 2019), who argues that Freud's greatest discovery was free association, and that "radical psychoanalysis" offers the patient and analyst a glimpse into the repressed oedipal world, and thereby a chance to come to terms with man's inescapable "castratedness", and to be liberated from "repetition-compulsivity". For Barratt, psychoanalytic metapsychology is largely outdated, and represents Freud's wish in his later years to leave an enduring "legacy".

A burgeoning urban middle class and post-Catholic culture have made South America a fertile seedbed for psychoanalysis. The early leading figures trained in Europe and then returned to South America to establish their own schools. Argentinian Horatio Etchegoyen's *Fundamentals of Psychoanalytic Technique* (Etchegoyen, 1991) is a masterly account of Kleinian psychoanalysis. Racker's (1968) contribution to the understanding of countertransference is now widely accepted (see Chapter 5). Psychoanalysts in Latin America have also played an important part in bringing their ideas to bear on psychoanalytic concepts (Matte-Blanco, 1975), the processes of political upheaval (Hoggett, 1992), and the special technical skill and courage needed to continue working psychoanalytically in a culture in which death threats and "disappearances" were endemic (see Lewkowicz & Flechner, 2005).

Psychoanalysis in Continental Europe

With its emphasis on finding and facing the truth, and the goals of autonomy and personal freedom, psychoanalysis and totalitarianism are incompatible. Fascism obliterated psychoanalysis in Germany for at least a generation and, with Pavlovian behaviourism the official party line in psychology, Stalinism similarly prevented the growth of psychoanalytic ideas throughout Eastern Europe.

Today, however, from a British and United States' perspective, the situation of psychodynamics in the German-speaking world (Germany, Austria, and Switzerland) appears paradisal. Psychotherapy, including psychoanalysis, is treated as a medical speciality, equivalent to physical medicine, and is covered by private and government insurance schemes up to a total of 300 sessions. The historical reasons for this lie in part in reaction against the shameful Nazi dismantling of the "Jewish science" in the 1930s (which, ironically, led to the flowering of psychoanalysis in the United

Kingdom and United States) and also to the fact that research in psychotherapy outcomes was initiated in Germany in the 1950s, some 20 years before the need was felt in the Anglophone world. Today, Germany remains at the forefront of both process and outcome studies in psychodynamic psychotherapy. The Berlin psychoanalytic university is the first of its kind in the world.

Psychodynamics are similarly valued in the Scandinavian countries. In the 1970s, an interesting development was "shuttle training", in which a group of British psychoanalysts and group analysts went regularly to Denmark to "train the trainers" until a sufficient cadre had been established for self-sufficiency. Similar arrangements have more recently been developed in Russia, Eastern Europe, and China, where, following the demise of communism, there has been a hunger for psychoanalytic ideas and therapies. With developments in electronic communication, video-conferencing supervision helps to maintain a psychoanalytic culture in these hitherto-deprived regions.

France was, through Freud's contact with Charcot and Janet, a vital seedbed for psychoanalysis. The central place held by philosophy in French thought meant that the "isms" – Existentialism, Marxism, and, later, Structuralism – all influenced the shape taken by psychoanalytic thinking, as well as representing rival philosophical systems. French psychoanalysis is strongly factionalised, with many rival groupings and "groupuscules" (Turkle, 1978). The dominant figure – a focus for admiration or disagreement – has been Jacques Lacan (1964), who, in his tantalising and gnomic texts, has synthesised Sassurian linguistics with psychoanalysis (see Chapter 3). In his view, the oedipal child enters a world of "signs", which convey to him the meanings of self, gender, and the body, just as he is similarly confronted by language and grammar, which he must assimilate to become part of the linguistic community. Lacan was critical of Hartmannian ego psychology with its emphasis on adaptation – perhaps an example of a more general resistance among French intellectuals to what they see as American cultural imperialism. Lacan called for a "return to Freud" – that is, to pre-"structural model" Freud (see Chapter 2). He described three developmental stages: first, a primordial period of unconscious infantile "desire"; then the world of "the imaginary" emerging from the "mirror stage", in which the child first confronts his image and narcissistically – and therefore incorrectly – assumes this to be his true self; and finally the "symbolic order", arising through the contact with language, the "no(m) du père", a linguistic expression of Freud's picture of the father's combined role as necessary separator of child and mother, ego ideal, and potential castrator. Successful therapy depends on the exploration of desire through the symbolic order of language, and consequent disentanglement from the world of the imaginary.

Within mainstream psychoanalysis in France, Laplanche and Pontalis (1973) have produced the definitive dictionary of Freudian concepts. Laplanche's (1999) later elaboration of the analyst as "enigmatic signifier"

has been a key contribution. André Green (2011) developed a variant of the Winnicottian notion of "space" – the space between the analyst and patient where creativity and growth can occur, but also a location for despair and non-existence, or, in his terms, "the absent mother". Joyce McDougall (1978), a New Zealander living in Paris, wrote influentially about the psychoanalytic treatment of psychosomatic disorders. Janine Chasseguet-Smirgel (1985) is an important figure in feminist psychoanalysis, postulating a fundamental male fear of the all-encompassing female, and seeing the phallic response to this in the oedipal child through the development of a "faecal penis" or pseudo-penis. She is able to analyse a wide range of clinical and cultural phenomena, including perversions and some aspects of revolutionary politics – a focal point for enthusiasm or reaction in the French imagination – in terms of this "excremental vision". We may also include here the French psychosomatic school, in which the concept of mentalisation (or mentalising) was elaborated. Mentalisation as part of French psychoanalysis was later taken up in the French-speaking areas of Canada, leading to interest in North America in how the concept has been further elaborated by Bateman and Fonagy (2004) as mentalisation-based treatment (see Chapters 10 and 11).

Psychoanalysis in Africa

In Africa, psychoanalysis is currently more or less confined to South Africa. For the non-white and rural population, mental disorders are largely treated by traditional healers, but there are now psychodynamically informed outreach projects in the townships, for example, for victims of sexual abuse. Narrative therapy for victims of war trauma is also conducted, and has been successfully evaluated and found to be helpful in controlled studies.

Psychoanalysis in Asia

In Asia, a number of non-theistic religions and psychological disciplines such as Daoism, Shintoism, and Zen Buddhism have been incorporated into professional treatment, raising the possibility of an authentic Asian psychoanalytic approach to mental illness and its therapy. There are flourishing psychoanalytic institutes in South Korea and Japan. Takeo Doi (1989) coined the term *amae* to describe a particular kind of mother–child intimacy unique to Japan, which has thrown new light on the kinds of intimate dependency psychoanalysis can foster. Salman Ahktar, an Indian psychoanalyst working in the United States, has questioned the neo-Kleinian emphasis on negative emotions such as envy and destructiveness, as opposed to hope, optimism, and humour, and has written about the positive influence of the psychoanalyst (Akhtar, 1992), illustrating how East–West dialogue in psychotherapy can become a two-way process.

Current psychoanalytic dilemmas and controversies

> We do not even require of our *patients* that they should bring a conviction of the truth of psycho-analysis into the treatment or be adherents of it. Such an attitude often raises our suspicions. The attitude that we find the most desirable in them is a benevolent scepticism. (Freud, 1917a, p. 244)

This brief historical and geographical survey gives, we hope, some feeling of the diversity and vigour of the psychoanalytic movement. It may also convey some of the controversy and debate that are continuing features of the movement. There is an inherent tension in psychoanalysis between the need for creative uncertainty – Keats's (1891, p. 48) "negative capability" – in order not to do violence to psychological reality, and the search for safe footholds in the uncharted terrain of the mind. The former can all too easily degenerate into muddle and mystery, the latter into dogmatism; both tendencies are to be found in the psychoanalytic literature. The remainder of this chapter is devoted to a consideration of some of the contentious issues with which contemporary psychoanalysis is struggling.

Psychoanalysis versus psychoanalytic psychotherapies

It is hard to produce a satisfactory definition of psychoanalysis that clearly differentiates it from the many forms of psychoanalytic psychotherapy it has spawned. Many of the psychoanalytic therapies can be looked upon as the children of psychoanalysis, with all the inevitable parent–child conflicts involved.

For Freud (1914b), the defining features of psychoanalysis as a treatment were the centrality of transference and resistance. Most psychoanalytic psychotherapies would also claim that these were central to their work and, conversely, there is no certainty that what is *called* psychoanalysis accords with Freud's criteria. Indeed, empirical studies of psychoanalysis (see Chapter 11) have failed to show a convincing relationship between the "development of an analytic process" (i.e., the creation and dissolution of a transference neurosis) and a positive outcome of treatment. Good outcomes are possible where the analysis of transference appears to play quite a minor part, and patients can do badly despite heroic efforts at transference interpretation.

In view of this, a pragmatic approach is needed. As an academic subject, psychoanalysis can be defined as the branch of psychology initiated by Freud that is concerned with three distinct areas of study: the development of the mind and the influence of early experience on adult mental states; the nature and role of unconscious mental phenomena; and the theory and practice of psychoanalytic treatment, particularly transference and countertransference.

This definition is by no means entirely satisfactory. By being tied indissolubly to Freud, psychoanalysis runs the risk of confirming Whitehead's (1916, p. 413) warning: "a science which hesitates to forget its founders is lost" – and yet Freud remains a colossus, "the father who does not die" (Wallerstein, 1992). More significantly, the definition contains a potential circularity, in that psychoanalysis is defined at least in part as the study of psychoanalytic treatment. At this point, the discussion usually moves to the easier, but equally tautologous, definition of a *psychoanalyst* – that is, someone who has undergone training at one of the organisations recognised by the International Psychoanalytical Association. However theoretically unsatisfactory this definition may be, the pragmatic demarcation line between psychoanalysis and psychoanalytic psychotherapy concerns the frequency, intensity, and duration of therapy. Put simply: more than three times a week – psychoanalysis; three times or less – everything else.

While accepting this distinction, several caveats must be considered. First, the emphasis on "How many times a week?" produces a bias in contemporary psychoanalysis, certainly not present in Freud's early work, towards the primitive anxieties that emerge during the regression evoked by such intensity. Second, even the more than/less than three times a week boundary is not watertight, because some French and Latin American psychoanalytic societies accept three-times-a-week training analyses. More research is needed to establish the effects and indications of different treatment intensities. We take a provisional view, seeing psychoanalytic therapy as a spectrum ranging from "full" psychoanalysis to the various forms of psychoanalytic psychotherapy; from the use of methods that are expressive to those that are supportive; and from interventions that rely mainly on interpretation to those that emphasise "holding" techniques.

One psychoanalysis or many?

The problems of line-drawing are not confined to those between psychoanalysis and other psychotherapies. Psychoanalysts also struggle with the question of whether the many different varieties of psychoanalysis – Freudian, Kleinian, Kohutian, Interpersonal, Lacanian, Object Relational, and Independent – can all meaningfully stay together as "common ground" bedfellows. The "gentlemen's agreement" worked well in Britain in 1948 and kept the society from falling apart, but is it fit for 21st-century purpose?

Wallerstein (1992) was a strong proponent of the "common ground" position, claiming that all the different theoretical approaches have, in clinical practice, much in common. One way to examine this notion is to compare the responses of analysts with different perspectives to the same clinical material. A number of psychoanalytic journals have formalised this methodology, and the International Psychoanalytical Association similarly initiated an ambitious 10-year research programme attempting to clarify the parameters of the discipline (Tuckett, 2008).

Example: An unscheduled analytic break

Wallerstein (1992) discusses Kohut's (1984) account of a discussion with a Latin American colleague about a patient who withdrew into silence in response to the announcement of an unplanned cancellation of a session. The Kleinian analyst had interpreted this in terms of a shift from the patient's perception of the analyst as a warm, feeding breast to a cold, withholding one, retaliating in kind by "biting back" the rejecting words she felt welling up inside her. Kohut claimed to be surprised to learn that this interpretation – delivered in a warm, empathic way – elicited a favourable response from the patient. In his view, it was "far-fetched", and what the analyst *should* have interpreted was the patient's feeling of losing a sustaining self-object, with consequent inner deadness and emptiness. Wallerstein himself offers a third possible interpretation along the lines of oedipal exclusion from the parental bedroom.

Wallerstein argues that the differences between these interpretations are more apparent than real: what really matters is that the patient has reacted unhappily to the unplanned cancellation and that the analyst has picked up on this – that is, on the "present transference" (Sandler & Sandler, 1984) – and explored it with the patient. Following Rapaport (1951b) and George Klein (1976), he distinguishes *clinical* theory from *general* theory. He sees a common ground of clinical theory, concerning empathy, holding, interpretation, defence, analysis of transference, and resistance, all of which are observable, testable, and researchable. In contrast, he sees metapsychology as reflecting the different traditions, styles, and historical contexts of psychoanalysis: "pluralistic psychoanalytic articles of faith", "metaphors we live by", more akin to political and religious affiliations than scientific postulates. While at a political level Wallerstein's efforts have done much to reconcile warring factions within psychoanalysis, real intellectual differences remain, and doubtless the debates will continue.

Pine's (1990) eclecticism takes a different slant. He sees Drive, Ego, Self, and Object as each referring to a different segment of reality, each with its appropriate metapsychology and set of technical procedures. The task of the therapist is to focus on whichever is relevant at any particular time in the evolution of the analysis.

These attempts at synthesis run the risk of glossing over real differences and inhibiting creative conflict and debate. Sandler (1983) notes the *elasticity* of psychoanalytic concepts, which enables the theoretical contortions to occur. New ideas, rather than superseding old ones, tend to be grafted on to them, so that notions such as transference or projective identification simply

expand to accommodate conceptual innovations, thereby becoming increasingly "baggy" and unwieldy (and confusing for the student!). Greenberg and Mitchell (1983) see the contrast between drive theory and object relations as irreconcilable, reflecting fundamentally differing philosophical viewpoints. Schafer (1990) regrets the search for a "single master text for psychoanalysis", and celebrates the battles and disputes within psychoanalysis, arguing that "sublimated aggression does have its uses". Doubtless, individual psychoanalysts' personal histories and psychodynamics affect their espousal of a pluralistic or sectarian position. There is of course an arbitrary or accidental aspect too: just as our attitudes and fundamental beliefs are affected by the family in which we grow up, so analysands – other than the outstanding pioneers – tend to stick to the tradition represented by their training analyst. Both pluralism and sectarianism have their defensive aspects. The pluralist may be fearful of the aggression inherent in choosing *this* viewpoint in preference to *that*. Conversely, the champion of one particular sect may be splitting off unwanted parts of the self in a manic and triumphal way to avoid the inherent difficulties of the "impossible profession" (Freud, 1937).

Our position is one of qualified eclecticism. Real and important differences exist between differing psychoanalytic perspectives. The capacity to see and respect the other's point of view while remaining true to one's own is not easy. Our approach is close to Wallerstein's in that we try throughout to remain near to clinical reality, while at the same time trying to bring scientific findings to bear on psychoanalytic thinking. Where different languages are describing the same phenomenon we try to point that out; where perspectives are irreconcilable, that too is noted.

The scientific status of psychoanalysis

A central controversy in psychoanalysis concerns the question of whether, as Freud hoped and expected, it is classified as one of the sciences – the science of the mind – or whether it belongs with the arts-based, historical, hermeneutic (i.e., interpretive) disciplines, or indeed whether, as a mixture of both, it is, as Rycroft (1985) puts it, "*sui generis*". This debate has to be set in context, since we inhabit a society that values (and funds!) science above all else, and takes the "hard" physical sciences as benchmarks against which "soft" subjects like psychoanalysis are measured and, more often than not, found wanting.

The issue of the scientific status of psychoanalysis was initiated by the positivist critique, which saw psychoanalysis as an "ideological", closed belief system, lacking falsifiable postulates or a sound empirical basis. Insofar as analysts are prepared to listen to this attack, rather than dismiss it as an illustration of resistance or envy, it leads to two kinds of responses. One is to concede that *so far* empirical evidence for psychoanalytic propositions is flimsy, and intensify the attempt to find scientific ways to study the

phenomena in question. We have devoted the whole of Chapter 11 to this tack. Others claim that the search for a scientific basis for psychoanalysis is inherently misguided, arguing that it is a philosophical and linguistic discipline concerned with meaning and interpretation rather than mechanism and explanation (Home, 1966; Rycroft, 1985). Habermas (1968) and Spence (1982) go further. Habermas argues that the causation of mental phenomena is different in kind from those that exist in the physical world, while Spence asserts that psychoanalysis is concerned with narrative rather than historical truth. What matters, according to this argument, is not whether psychoanalytic constructions correspond to reality, but rather whether they are internally consistent and satisfying.

Here, the debate exemplifies the philosophical struggle between the *coherence* and *correspondence* theories of truth (Cavell, 1994), that is, depending on how robust and internally consistent a theory is, or how much it appears to correspond with the "facts" of external reality (but note that coherence theorists argue that what we call a "fact" is itself a construction and therefore subject to coherence criteria). Rorty (1989) argues that philosophical pluralism is all one can hope for, but there is an inherent flaw in this retreat into hermeneutics: if all that matters is coherence, how does one distinguish between the veridicity of different narratives? Is the psychoanalytic account – or the Lacanian or Kleinian version of it – no more or less true than a homoeopathic or astrological account of a patient's difficulties? Grünbaum (1984), in contrast to Habermas, argues that, although perhaps more difficult to study than in the physical sciences, cause–effect principles apply just as strongly in psychology as in physics. He also shows that many psychoanalytical postulates *are* falsifiable, and that Freud was quite capable of modifying or even abandoning his ideas if the facts demanded it. Using a rather simplistic and outmoded model of psychoanalytic change, he believes that Freud's "tally argument" (that patients get better if analysts' interpretations "tally" with historical fact) remains unproven.

Eagle (1984) claims that the hermeneutic position would suggest that psychoanalysis could only change or evolve "in the sense that fiction has evolved, say, since Fielding". While there may be some truth in this, conceptual clarification, technical innovation, and empirical testing of psychoanalytic ideas have also produced real advances in our understanding, for example, of primitive mental states (see Chapter 4) and of the minutiae of patient–analyst interactions (see Chapter 8).

Several contemporary developments have changed the terms of the debate on the scientific status of psychoanalysis. First, the advent of cognitive science (Bruner, 1990), stimulated by the computer revolution, means that the mind is no longer seen as out of bounds for hard-headed scientists. Many interesting parallels can be found between the findings of cognitive science and those of psychoanalysis (Teasdale, 1993). Psychoanalysis no longer needs to remain in splendid isolation from its sister disciplines

(Gabbard, 2000). Second, recent findings in developmental psychology have made the distinction between narrative and historical truth look less clear-cut. The Adult Attachment Interview (George, Kaplan, & Main, 1985) – a psychodynamic interview that can be reliably rated – indicates that there is a reliable link between the kinds of stories people tell about themselves and their lives, and their patterns of attachment in infancy and childhood. Third, Grünbaum's (1984) claim that the efficacy of psychoanalysis may be the result of "non-specific" factors such as attention, interest, regularity, and reliability, rather than, as he claims psychoanalysts believe, the accuracy of their interpretations, can be linked with findings suggesting that empathy and attunement in infancy lead to secure attachment, and that similar development-enhancing qualities may produce change in psychoanalysis.

Our position is, once more, a compromise. We do not see coherence and correspondence when applied to psychoanalysis as mutually incompatible. Theories and technical practices need to be coherent if they are to be robust enough to stand up to conceptual or clinical challenge, but also need to correspond with reality: their adherents must be prepared to modify them in the face of empirical evidence. Parts of psychoanalysis – unconscious awareness, repression, internalisation, and identification – are scientifically established phenomena. Others represent metapsychological superstructures, which may eventually be dismantled, amalgamated, or modified. Meanwhile, the clinical practice of psychoanalysis is concerned with stories, meanings, and interpretations, and these will continue to be the lifeblood of psychoanalytic work. Scientific investigation of these phenomena will inevitably come from the "third term" – to use Lewin's phrase, as discussed by Wright (1991), for the sibling or father watching the mother feeding an infant in the "oral triad" of scientific observation.

Neuropsychoanalysis

Govrin (2019) differentiates two types of innovation in psychoanalysis. What he calls "first-order" new ideas are extensions, elaborations, and developments of the fundamental principles laid down by Freud. An example would be the pathway from Freud's concept of defensive projection, through Klein's (1946) projective identification, Bion's (1962b) elaboration into communicative projective identification, and on to Heimann's (1950) advocacy of the analyst's countertransference as a cue to aspects of the patient's disavowed inner world (Spillius & O'Shaughnessy, 2012). "Second-order" innovations are developments from non-psychoanalytic sources that have significant implications for psychoanalytic theory and practice. An outstanding example of such a second-order innovation is *neuropsychoanalysis*, a term coined by Solms and Turnbull (2002) to encompass a rapprochement between psychoanalysis and neuroscience.

Freud started his professional life by studying the anatomy of the brains of lampreys. As psychoanalysis began to take shape, he still hoped for a discipline that could address both brain and mind, as outlined in his abandoned "Project for a Scientific Psychology" (Freud, 1895). Proponents of neuropsychoanalysis argue that the extraordinary advances in neuroscience now make Freud's hopes realisable (Northoff, 2012).

Solms (2019) reverses the classical Freudian model of an id located in the submerged "lower" parts of the brain while consciousness belongs to the more evolutionarily complex cortex. In Solms's model, consciousness is a property of the "lower" centres, the brainstem, while the dynamic unconscious is a property of the neocortex, in which impulses from below are selectively attended to or repressed.

In line with this model, neuropsychoanalysis questions the classical binary eros/thanatos drive model. Panksepp and others' (Davis & Montag, 2018; Panksepp, Lane, Solms, & Smith, 2017) *affective neuroscience* postulates seven basic motivational/emotional systems, shared with other primates and mammals, each with its own neuroanatomical and neurotransmitter architecture. These are SEEKING, CARE, LUST, and PLAY, and FEAR, SADNESS, and ANGER. The subcortical origin of affect is also evident in Feldman's (2020) picture of midbrain interplay between affiliation (oxytocin-mediated), reward (dopamine-driven), and fear (via the amygdala and the hypothalamic–pituitary–adrenal axis). Each of these has cortical representations, and much of the work of psychoanalysis can be thought of in terms of identifying and strengthening the regulatory influence of the neocortex on these basic and often conflicting emotional states.

Another neuropsychoanalytic dimension has emerged from the work of psychiatrist and neuroscientist Karl Friston (2010a, 2010b) in his "free energy model", which postulates that the brain's aim is to maintain energetic homeostasis, using predictive "top-down" models of the world to "bind" incoming "bottom-up" impulses from the body and the sense organs, and therefore to avoid excessive "surprise". Carhart-Harris and Friston (2010) saw the parallels between this model and Freud's "Project" (1895), which also postulates the need to reduce energy (or "Q", also known as "libido") either through "discharge" (i.e., action) or by thought. In Freud's model of neurosis, hysterical symptoms represent unbound libido, due to oedipal repression or (in his later model) superego prohibition, transmuted into physical or psychological symptoms. Reversing this by turning libido into verbal representation – that is, "binding" – via therapeutic conversation is the psychoanalytic remedy.

From a contemporary free-energy perspective, the work of psychoanalysis can be understood in a number of ways (Connolly, 2018; Holmes, 2020; Hopkins, 2016; Solms, 2018). The "virtual" nature (i.e., it is not "real life") and ambiguity of the session and patient–analyst relationship decouples "bottom-up" from "top-down", and enables experience and how it is repressed or distorted by pre-existing models to be thought about. *Dream*

analysis (see Chapter 6) enhances the range and complexity of narratives available for thinking about experience. *Transference analysis* (see Chapter 5) highlights the limited and often conflictual stereotyped models that make up the troubled relationships that patients bring to analysis. *Free association* (see Chapter 8) extends the range of "bottom-up" information that is accessib le and enables patients to listen better, both to their own bodies and to the communications of those close to them. Finally, psychoanalysis fosters the *agency* needed to revise outdated relational models and make better choices.

For some analysts, neuropsychoanalysis is a diversion from the essential project of psychoanalysis (Blass & Carmeli, 2015). For our part, we welcome the increasing dialogue between neuroscience and psychoanalysis, and await the theoretical and therapeutic opportunities it offers.

How does psychoanalysis cure?

Kohut (1984) asked this question in trying to differentiate his own approach, based on empathy and the establishment of nurturing selfobjects, from the "classical" view of interpretation and insight as the sole vehicle of cure. Kohut's notion is not so far removed from Grünbaum's (1984) suggestion that "non-specific" factors might explain good outcomes in analysis. Following Freud's epigrammatic characterisation of psychoanalysis as "transference plus resistance", three main positions on the mode of action of psychoanalysis can be identified (Steiner, 1992), each of which implicitly has a view about what constitutes psychological health.

1. *Classical/conflict model*
   In this formulation, the ego has repressed "problematic experience" to maintain coherence. This maladaptive solution or compromise, in which satisfaction is sacrificed for the sake of security, is reproduced in the transference: the patient feels angry or amorous or wants to be looked after by the analyst, but resists giving vent to these feelings. The aim of treatment is to help the patient gain insight into these processes, and use this awareness to respond more fully to his experience. As Freud (1933, p. 80) famously put it, "Where id was, there ego shall be".
2. *Kleinian-object relations/conflict model*
   Here, there is a conflict between love and hate, between the need for an object on which to depend and the fear of its loss. To guard against internal fission, destructive impulses are projected, thereby depleting the self. Transference is shaped by processes of projective identification and misperception. The task of the therapist is to contain these projections and to return them when the patient is able and ready to accept them (Bion, 1962a). Resistance centres around the difficulty in acknowledging dependency on an analyst whose "good breast" – that is, helpful

ambiance and apposite interventions – will then be an object of envy and potential loss. Analysis moves the patient from the splitting of the paranoid–schizoid position to the wholeness of the depressive position.

3. *Interpersonal–object relations/deficit model*

   Here, the focus is on the "present transference" – the living unconscious interplay between analyst and patient. Resistance is seen not in terms of conflict, but as a manifestation of deficit. The patient is compromised by their developmental experiences and is unable to react non-neurotically. Under the regressive pull of treatment, the patient clings to old maladaptive patterns because he or she knows no other way ("better a bad object than none at all"). Treatment produces change by offering a new experience of empathy and attention, from which the patient can build a secure sense of self and of helpful relationships.

In summary, these models see analytic cure as resulting from *insight*, *containment*, and *new experience*, respectively. Most analyses contain elements of all three, and none can be reduced to a singular approach. Thus, "Kleinian" therapy centres around insight and containment, "Kohutian" analysis on containment and new experience, contemporary Freudian approaches on insight and new experience, and so on. Here, in line with Wallerstein's (1992) "common ground" viewpoint, the nearer one approaches clinical reality, the more the distinctions look blurred; the further one "zooms out" to metapsychological positions, the more sharply focused the differences become.

Training

If psychoanalysis is one of the "impossible professions" (i.e., one in which it is impossible to predict outcome with certainty; Freud, 1937), psychoanalytic training poses some insoluble dilemmas. The plurality of psychoanalysis, the problem of its definition, divergent views on the process of cure and change, the elasticity of concepts, and cultural differences mean that psychoanalytic trainings around the world are diverse in both their form and content. These diversities include how candidates are admitted for training, how training analysts are selected, their role in the candidate's training, the number of treatment sessions per week, the content of supervision and seminars, the importance attached to infant observation, the length of training, and the processes of qualification. Even the method of payment for personal analysis varies – in some European institutes, candidates are not allowed to reclaim session fees even if their insurance company accepts the claim, illustrating the large financial commitment entailed in psychoanalytic training.

Ideally, the *process* of training should educate but not indoctrinate, and encourage freedom of thought within a psychoanalytic framework without espousing any one variety of psychoanalysis. The *organisation* of training

reflects the need to regulate the expression of powerful transference and countertransference reactions within the training process. These are ubiquitous: between the candidate and their analyst, the candidate and their patient, the candidate and their supervisor, the supervisor and the analyst, and the analyst and the institution. A "good enough" distance between these dyads and between the training analysis, supervision, and the institution provides the right conditions for learning and development; an intrusive system leads to fear of self-expression and, at worst, the development of analytic clones created in their analyst's image. Each candidate needs to identify, dis-identify, separate, and gain independence. All these aspects have come under intense scrutiny and criticism (Kernberg, 2014).

Psychoanalytic values

In Auden's (1952) obituary poem, he wrote: "Freud is no more a person now but a whole climate of opinion". Although the focus of this book is almost entirely clinical, it is important also to acknowledge the moral and cultural significance of psychoanalysis. Freud (1930) saw society as a thin veneer of civilisation, not unlike the ego in relation to the id, resting on a sea of primitive eroticism and aggression. His advocacy of balance and courage in the face of destructiveness – his "tragic vision" (Schafer, 1976) – and of the power of sublimation of baser drives into cultural achievement make Freud as much a moralist as a scientist (Reiff, 1959).

Freud's cultural and moral critique is to be found in the concerns of contemporary psychoanalytic writers, many of whom emphasise the ambiguity of the psychoanalytic vision, which both exposes and to some extent legitimises and therapeutically strengthens the very society it criticises (Barratt, 2019; Frosh, 1997). This ambiguity is evident within feminist psychoanalysis, which has moved from its hostility to Freud's phallocentrism to an appreciation of how psychoanalysis can help to understand the development of gender, how the notion of bisexuality suggests the cultural relativism of patriarchy, and how psychoanalysis as a therapy can help women to find their true selves rather than necessarily producing pressure to conform to male values and visions (Benjamin, 1988; Irigaray, 2012). Even Lacan (1964), with his insistence that paternal law is unavoidable, also shows how alienated selves can be found through the discovery of discourse – a key aspect of successful psychoanalysis is the finding of one's own voice and with it a strengthened sense of self.

Klein-influenced cultural critics (Young, 1994) emphasise how psychotic processes of projection, splitting, perverse destructiveness, hatred, and sexual violence lurk not far from the surface of domestic and political life. The moral stance of psychoanalysis includes a number of concerns that are central to social and political debate (Morgan, 2019). First, there is an overriding valuation of the truth, of the need to face reality, however

painful, rather than turn a blind eye (Steiner, 1993). This leads to scepticism about simplistic solutions in which evil is driven out by love – a balance between the two is a more realistic possibility. Second, psychoanalysis makes a link between familial nurturance and the search for a good society: the "right to play" would appear on any psychoanalytic political manifesto. Third, psychoanalysis values autonomy as a good in its own right, independent of freedom from want – a view that is central to the liberal tradition – and demonstrates how the cradle of autonomy is sensitive parenting, the lack of which can, with luck, be remedied by psychoanalysis (Holmes & Lindley, 1994).

Such diverse ideas spring from the metapsychological superstructure of psychoanalysis. However, if psychoanalysis is to be based on more than myths or wishes, it must rest on firm foundations of clinical theory and practice – the exposition of which forms the rationale and purpose of this book.

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Chapter 2

Models of the mind

> Such ideas as these are part of a speculative superstructure of psychoanalysis, any portion of which can be abandoned or changed without loss or regret the moment its inadequacy has been proved. (Freud, 1925, p. 31)

Freud's archaeological metaphor (see Chapter 1), in which new ideas are built on earlier foundations, applies to psychoanalytic theory itself. Some ideas are re-worked, whereas others are retained in almost their original form. Freud himself continually revised his theoretical models and he was not afraid to change them radically when the need arose. His successors have happily followed his example and psychoanalytic models of the mind have undergone many developmental changes. As a result, most are mixed models, not necessarily building a coherent whole, but forming a complex matrix of ideas containing concepts at different levels of abstraction. Contradictory formulations sometimes sit uncomfortably side-by-side, in part because psychoanalytic theory occupies several different levels of abstraction.

Waelder (1960) identified the following levels:

1. Clinical interpretation – a theory or formulation about a specific patient.
2. Clinical generalisations relevant to specific groups of patients, for example, "narcissistic organisations" (see Chapter 4).
3. General psychoanalytic concepts such as defence mechanisms or transference. This is the level with which we shall be primarily concerned in this chapter.
4. Overall explanatory concepts such as the Oedipus complex or the death instinct.

Underlying different theoretical approaches are varying fundamental assumptions about the world: how much experience is determined by the environment, and how much it is innate; whether a basically hopeful or

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"depressively realist" viewpoint is adopted; whether a mechanistic or humanistic view of the mind is taken; the balance between determinism and freedom; on the emphasis on impersonal mental forces as opposed to meanings and language; whether a position of mentalism or realism is adopted; and the extent to which psychological phenomena are viewed as primarily intrapsychic or interpersonal.

All these issues have been discussed by philosophical and cultural observers of psychoanalysis (Appelbaum, 2013; Cavell, 1988, 1994; Greenberg & Mitchell, 1983; Holmes & Lindley, 1989). From the clinical perspective of this book, two dimensions stand out. First, the balance between environmental or intrapsychic factors in the development of the personality; second, whether the emphasis is on causation and mechanism in approaching mental phenomena, or on understanding and meaning. At different times, Freud found himself on both sides of these discussions. Initially, he placed the emphasis more on environmental factors, especially traumatic external events such as childhood seduction or battle neurosis. In his later drive-structural model, Freud saw the internal world as primary. External events were not so much causative as triggers that released inherent patterns such as the Oedipus complex. This difference of emphasis continues to this day. We shall characterise models as intrapsychic, interpersonal, or mixed. Similarly, although Freud set out to produce a scientific and causal picture of abnormal mental life, as his work evolved he became more and more concerned with meaning, narrative, and communication.

The dilemma faced by clinicians is that to practise effectively, especially at the outset of one's career, a firm theoretical framework is needed; at the same time, it is unlikely that any one model holds the key to all the workings of the human mind and human motivation. In practice, most analysts draw on a mixture of different theories, even if their basic allegiance is to a particular school. This chapter contains a schematic overview of the main psychoanalytic concepts and models, each of which will be elaborated in the course of the book (cf. Auchincloss, 2015).

The unconscious

The concept of the unconscious is generally seen as synonymous with psychoanalysis. Although Freud did not "discover" the unconscious (Ellenberger, 1970; Hopkins, 2012), he was the first to explore systematically its role in normal and abnormal mental life. From a contemporary perspective, the unconscious is conceptualised in one of four basic ways.

The unconscious as a "thing in itself"

Freud initially saw the unconscious as part of the "mental apparatus" (Laplanche, 1989), a Kantian entity that could not be directly apprehended

but determined "irrational" mental phenomena such as dreams, neurotic symptoms, and slips of the tongue. He postulated that unacceptable memories, phantasies (the "ph" differentiating them from "fantasies" in the everyday sense of daydreams or conscious wishes), wishes, thoughts, ideas, and aspects of painful events were pushed back by repression into the unconscious, along with their associated emotions. In Freud's unpublished "Project", he hoped to produce a neurobiological account of the role of the unconscious, based on the flow, binding, and discharge of psychic energy, or libido. Although this "hydraulic" model has largely been superseded, modern neuropsychology has confirmed, via subliminal perception and "preconscious processing", that many aspects of mental life vital to survival take place outside of awareness (Dixon & Henley, 1991; Solms, 2018b). This leads to a distinction between the "descriptive unconscious", that is, aspects of our mental life of which, like other parts of our physiology, we are simply unaware, and the "dynamic unconscious", a purposeful repression of potential mental pain or conflict.

The unconscious as reservoir of latent meaning

With the shift in contemporary psychoanalysis away from mechanism towards meaning, "the unconscious" becomes a metaphor for the affective meanings of which the patient is unaware, and which emerge through the relationship with the analyst. "Unconscious" becomes an adjective rather than a noun: "unconscious processes", rather than "the unconscious". This links psychoanalysis with the "post-modern" notion of polysemy or multiple meanings which are to be found in any cultural phenomenon or "text". The analyst's task, rather than being an anatomist of the mental apparatus, is to explore these latent meanings collaboratively.

The mystery of the unconscious

Jung (1916) and his commentators (Corbett, 2012; Fink, 2011) emphasised a less tangible, quasi-mystical aspect of the unconscious. He was particularly interested in religious and spiritual aspects of human experience, and introduced the concept of the "collective unconscious". He thought this consisted of a pre-existing set of meanings and symbols, common to all mankind, present at a deeper layer of the mind than the personal unconscious described by Freud. He based this view on the finding that the beliefs and mythology of widely different religions and cultures have had a great deal in common throughout the ages and in different parts of the world. He then applied this to his patients, claiming that dream themes such as water, or snakes or mandala-like patterns, represented the "psychic genetic inheritance", which precedes the specificity of individual experience.

Past unconscious and present unconscious

Sandler and Sandler (1987; Sandler, 2018) made a clinically useful distinction between the "past unconscious" and the "present unconscious". The past unconscious of the adult is the "child within" that continues in an unmodified form to have a powerful role in determining the adult's responses, wishes, and needs, as if childhood were still operating. More akin to the preconscious (described later in this chapter), the present unconscious is concerned with maintaining equilibrium in the present and modifies the past unconscious, allowing the past unconscious phantasies some expression, albeit in an attenuated form. The past unconscious operates according to archaic object representations and reacts according to the past, whereas the present unconscious operates with representations as perceived and imagined in the present. The Sandlers argue that, in treatment, the analyst should always work from present unconscious to past unconscious, to attend to the here-and-now of the analytic interaction before proceeding to reconstructions of past traumas.

Freud's models

Freud's picture of the mind evolved through three main phases: the affect-trauma model, the topographical model, and the structural model (Sandler, 1972).

The affect-trauma model

Freud's earliest psychoanalytic ideas were influenced by experiences with casualties from the 1870 Franco-Prussian war, in whom hysterical paralyses seemed to be related to traumatic experiences at the battle front, which were relieved once sufferers were able to speak about (abreact) the terrifying events they had gone through. Freud then noted the frequency with which his hysterical patients, mainly women, reported adverse sexual events in their childhood. He therefore speculated, by analogy with battle trauma, that painful external events such as sexual abuse could overwhelm the "mental apparatus", leaving it unable to deal with the resulting affects, which became manifest in the symptoms of hysteria – pain, paralyses, dissociative states, unexplained fits, and so forth. He differentiated between "actual neuroses" (neurasthenia and anxiety), which he believed were caused by current trauma (now seen in terms of post-traumatic stress disorder), and the "psycho-neuroses" (hysteria and obsessional neurosis), which he saw as the result of childhood trauma. The two are clearly related in that childhood trauma is a predisposing factor that would make an individual more susceptible to the impact of current trauma, as suggested by Garland (2002).

The idea of the release of "dammed-up" affects (i.e., feelings), threatening psychic equilibrium and potentially leading to symptoms, has been called the "affect-trauma" frame of reference forming part of the first phase of Freud's metapsychology (Zepf & Zepf, 2008). Affect-trauma continues to play an important part in contemporary psychoanalytic thinking, especially since the reality of childhood abuse – whether physical, emotional, or sexual – and their long-term effects on physical and mental health have become established (Anda et al., 2006). The nature of infantile trauma is viewed differently by different authors, some emphasising intrapsychic factors, others stressing environmental influences. From an intrapsychic perspective, Klein (1946) and Kernberg (1975) see the intensity of childhood hatred, aggression, and envy as internally traumatic and speculate that potential borderline personality disorder sufferers may experience an excess of such unassimilable negative emotions, leading in turn to excessive splitting and projection (see Chapter 4). In contrast, for Kohut the primal trauma is interpersonal: a failure of parental empathy, leading to disruption of a coherent sense of self and the emergence of "disintegration products" in later life such as aggression, or attempts at self-soothing through addiction, compulsive sexuality, and even self-injury.

In both accounts, trauma arouses painful affect, which is then "banished" from consciousness, at the price of physiological disequilibrium and/or the absorption of psychic energy to keep pain at bay, which would otherwise be available for love and play. Bower (1981) found that the recall of memories is affect-dependent. Some memories can be recalled only when the same mood state is present as when they were laid down. This means that the "replay" of trauma that can happen in transference enables it to be reworked in a less overwhelming way: loss can be grieved, and anger expressed, leading sometimes to acceptance or even forgiveness.

The topographical model

In Greek, a *topos* is a place; *topography* describes the physical disposition of a terrain. Freud (1915, 1925) refers to "the topographical approach" and to "the topography of mental acts", encapsulated in his iceberg metaphor, in which the conscious mind rests on a much larger but submerged unconscious, with an intermediate zone of non-repressed but not currently active memories and thoughts in the preconscious. This division of the mind into unconscious, preconscious, and conscious systems ushered in the second phase of Freud's work (1897–1923), still containing echoes of cerebral localisation, a reminder of Freud's previous career as a neurologist. Contemporary psychoanalysis still uses topographical concepts but divested of their anatomical overtones, as did Freud by seeing each part of the mind as a "system" – the "system unconscious", the "system preconscious", and so forth. This enables a smooth transition to the "structural model" (see

later in this chapter), which is primarily concerned with the role and functions of the different parts of the mind. Current neuroscience accepts both topographical and systemic elements. The triune brain (Heimer, Van Hoesen, Trimble, & Zahm, 2008) – reptilian (medulla), paleo-mammalian (mid-brain), and neo-mammalian (cortex) – is topographical; but brain function is now viewed in non-topographical terms as a series of interlinked nodes or hubs in a network, such as the *limbic system* (Oldham & Fornito, 2019).

The "two principles"

A fundamental idea that comes out of this phase of Freud's theoretical development is his contrast between the "two principles of mental functioning" (Freud, 1911), the *primary and secondary processes.* Secondary process thinking is rational and follows the ordinary laws of logic, time, and space. Primary process thinking is typical of dreaming, phantasy, and infantile life in which the laws of time, space, and logic do not apply. In primary process thinking, past, present, and future can coexist, different events may occur simultaneously and in the same place, and one verbal signifier or visual symbol may represent a number of different objects, or have several different and even contradictory meanings. Being conversant with primary processes is an essential prerequisite of analytic work, and one of the many reasons why personal therapy for analysts is *de rigeur.*

Unconscious and preconscious

Freud realised that, due to the nature of *selective attention*, many psychological processes are unconscious in a descriptive sense in that the individual is not aware of them, but they are easily brought to mind. Thus, they are neither subject to repression nor operating under the sway of the primary processes. These unconscious but non-repressed phenomena he attributed to "the system preconscious", whose role in the topographical model is primarily as a reservoir of accessible thoughts and memories. However, as his ideas evolved, he came to realise that the preconscious could also act as a *censor* capable of modifying instinctual wishes of the system unconscious and so render them acceptable to the system conscious.

Instinct theory

The change from the affect-trauma frame of reference to the topographical model represented a significant shift in the evolution of psychoanalytic theory. The spotlight moved from a focus on external reality and its impact to the nature of the internal world itself, which Freud saw as dominated by humanity's struggle with the instincts, or *drives*.

Instinct or drive theory was put forward by Freud to explain human motivation. Confusion has arisen because the term "instinct" was used by Strachey to translate both "Instinkt" and "Trieb" from the German text. Although the terms are used more or less interchangeably by Freud, Instinkt refers to *innate behaviour patterns and responses.* Freud considered instincts as basic developmental needs constituted from phantasies, which had a peremptory quality and required expression and gratification. The more motivational term Trieb implies a pressure or push towards a general goal, such as survival or reproduction.

Freud was always an "obstinate dualist" (Jones, 1953). In his initial formulation of instincts, Freud (1905) emphasised the sexual or libidinous drives both in normal development and in the origins of psychological illness; later, he emphasised the aggressive and destructive drives or "death instinct" (Freud, 1920, 1930). This became known as the dual-instinct theory, although Freud had earlier stressed the self-preservative (i.e., death-defying) instincts alongside libido. The individual was at the mercy of these drives, or instinctual wishes, with adult symptoms arising from the psychological defences mobilised to deal with their "primitive" infantile demands. These wishes form part of the system unconscious, have an innate need for "discharge", and, to achieve this, become connected during development to an object.

In this classical schema, instinctual *wishes* have a *source* and an *aim* as well as an *object*. Their infantile source or origin is in the body and may be an "erogenous zone" such as the mouth, anus, or genitals; sensations in these bodily areas develop levels of tension, which aim towards discharge. The infant experiencing hunger sensations aims to reduce them by sucking. Gradually, his activity increases until the object of the instinctual wish – the mother's breast – is provided and hunger is satiated. The presence of the object and its quality is remembered, and the next time the infant feels hungry the memory of the breast is revived and the phantasy is once again enacted. The source, the aim, and the object begin to mesh together into a complex interactional phantasy, part of which is represented in the system unconscious.

Although in this example, the experience and revived memory derive from a real event – feeding – its need for expression and subsequent satisfaction can also arise in relation to an imagined occurrence. If an infantile, wish-fulfilling daydream is "lived" within the self and later repressed, the system unconscious will treat the imagined events according to the principles of primary process and, therefore, as if they were real. This observation is clinically important in relation to the issue of recovered memories. The distinction between the recovery of a traumatic memory and the revival of a wish-fulfilling fantasy, both subject to repression, is often difficult to make in the clinical situation. Both need to be treated with caution.

Limitations of the topographical model

Clinical experience led Freud to acknowledge an increasing number of inconsistencies in the topographical model. Foremost among these was the realisation that there was no place within his map of the mind for *ideals*, *values*, and *conscience*. Moreover, he recognised that the influence of the external world on mental structures and the unconscious nature of defence both needed more exploration. For example, anxiety had initially been seen as a result of the accumulation of repressed "somatic sexual excitement", or libido (see Chapter 1), which was transformed from a sexual wish into an unpleasant feeling; that is, as arising entirely from within. But it became clear that anxiety also arises in response to threat, either directly or as part of a psychological conflict induced by the threat. For example, a child who feels anger towards a neglectful parent may be fearful of expressing this anger for fear of losing the parent altogether. The internalisation of this parent–child relationship was hard to reconcile with the topographical model.

In his papers *On Narcissism* (Freud, 1914) and *Mourning and Melancholia* (Freud, 1917), Freud had begun to stress this interaction between the internal and external worlds, especially in his concepts of *introjection*, *internalisation,* and *identification*. He began to wonder how an experience of, say, a harsh or punitive parent comes to form a structural part of an individual's internal world.

Structural theory

The advent of the *structural model* (Freud, 1923) was Freud's attempt to answer these questions, heralding the third and final phase of his theorising (1923–1939). Given that "the unconscious" had been "discovered" by Freud's predecessors, poetic and scientific, it also perhaps represents the ageing Freud's wish to create an enduring theoretical legacy, uniquely his own (Barratt, 2019).

In the structural model, Freud (1923) proposed three parts or "structural components" of the human personality, translated – or, according to Bettelheim (1985), mistranslated – as the familiar id, superego, and ego. As with topographical theory, these are nowadays best thought of as *functions* rather than as structural entities, psychological configurations showing a slow rate of change and reactive stability (Friedman, 1978; Rapaport, 1967). The structural model retains aspects of instinct theory, in that the "id" refers to the inborn sexual and aggressive impulses. But the structural model is also focused on how an individual's personality structure adapts to the demands of these instinctual wishes. The structural model also built on the notion of the reality principle (Freud, 1911), heralding a move from a primary focus

on the internal world rather than on the external environment, to an emphasis on their interconnectedness.

Id

Freud borrowed the term "Das Es", the impersonal "it" or "Id", as Strachey translated it, from the psychosomatic physician George Groddeck. The latter was keen to emphasise the extent to which we are not fully in control of our bodies and minds but, rather, are lived by them. As Freud (1933, p. 105) puts it:

> It is the dark, inaccessible part of our personality…We approach the id with analogies: we call it a chaos, a cauldron full of seething excitations… It is filled with energy reaching it from the instincts, but it has no organization, produces no collective will, but only a striving to bring about the satisfaction of the instinctual needs subject to the observance of the pleasure principle.

Superego

Freud's (1914) earlier notion of the "ego ideal" became, in the structural model, the wider concept of the superego, or "over self". The "superego" is a repository of conscience and ideals derived through internalisation of parental or other authority figures, and wider cultural influences from childhood onwards. From an object relations perspective, the superego represents not so much an internalised parent as such but, rather, a *representation* of a parent into whom has been projected much of the individual's own aggression and punitiveness. The internalised parental and other figures of the superego are thus formed from phantasy as well as reality. A parent who is experienced in a superego-sense as harsh may in reality appear to have been relatively benign.

Given that the superego is conceived as shaping guilt, perfectionism, and preoccupation with what is the right or wrong thing to do, it plays an important role in the aetiology of depression, obsessional disorders, and sexual difficulties. But people vary in the extent to which they are conscious or unconscious of the impact of the superego on their lives. For example, some individuals may be quite clear that what they wish to do goes against accepted values or indeed against their own upbringing; in others there is an unconscious sense of guilt (Freud, 1923). Thus, a patient tormented by the need to perform obsessive–compulsive acts may have no conscious idea of why he is compelled to do something and feels excessively guilty if he omits to follow his compulsion.

Ego

The "ego", or "I", describes the rational, reality-oriented and executive aspects of the personality, and again is partly conscious and partly unconscious. Freud saw the ego's dual task as both controlling and adapting "primitive" id impulses to the world in accordance with the reality principle, and mollifying the requirements of the superego.

> The poor ego…serves three severe masters and does what it can to bring their claims and demands into harmony with one another…Its three tyrannical masters are the external world, the superego and the id (Freud, 1933, p. 76).

The structural model cannot easily be superimposed on the topographical model. While the system unconscious and the id are generally equivalent in functioning according to primary process thinking, once the id is also seen as a vital source of creativity and play, then those functions can be conscious. Conversely, the system conscious and the ego do not equate, because we are much of the time unconscious of how we defensively attempt to adjust to the interpersonal reality in which we are immersed. From the structural perspective, the key issue clinically is not whether the patient is conscious or unconscious of some aspect of himself, but what part of the mind holds sway: is the patient behaving and thinking according to the primary processes, under the dictates of an inappropriately harsh conscience, or ego-adaptively?

Conflict and adaptation

For the ex-neurologist Freud, there is an essential temporal contrast between reflex action, which is instantaneous, and the delay implicit in the inner world of the psyche. A wish is shaped, influenced, modified, held back ("free won't" as opposed to free will), diverted, or disguised by the "pale cast of thought". Instinctual wishes cannot obtain direct expression: within the topographical model they have to traverse the preconscious before they reach consciousness; in structural theory the superego and ego hold them back. By the time they reach consciousness they have been modified to such an extent that they can only be "back translated" through dream-analysis and unravelling transference. Instinctual wishes are clothed in the mechanisms of defence (see Chapter 4), mobilised to minimise internal conflict. This conflict arises because the instinctual wishes are under the sway of the "pleasure principle" (Freud, 1920), which does not necessarily conform to the demands of reality. For adults, one's childlike wishes and impulses will inevitably at times conflict with the strictures of adult life. Gratification of instinctual wishes is delayed or modified if they threaten the self-preservation of

the individual, or contravene his moral and ethical beliefs, or oppose the demands of his social and cultural environment.

Post-Freudian models

In the classical model, psychoanalysis tends to see the personality as a battlefield, beset by innate division and conflict, a struggle between internal demands and external reality, and often vain attempts at adaptation. Repression – sweeping all this under the carpet of consciousness – is viewed as the primary mechanism of defence. But incompatible wishes remain, and because of continuing pressure for the "return of the repressed" (a phrase akin to Nietzche's "eternal recurrence", neither of which Freud actually used; see Freud, 1933), psychic tension is inescapable.

Ego psychology

Heinz Hartmann (1939, 1964), the founder of ego psychology, questioned the conflict model, stressing instead the *non-defensive aspects of the ego* (for which he was himself much criticised by Lacan; see Chapter 3 for a discussion of the Lacanian perspective). Instead of the ego being a somewhat helpless mediator between the demands of the id and those of the external world, Hartmann conceived of the ego as standing outside this area of conflict, and thus able to interact freely with the external world, exercising discrimination and choice. In the Hartmann model, this "conflict-free sphere of the ego" develops independently, and flourishes unimpeded if environmental influences are reasonably favourable. It encompasses such functions as thinking, perception, language, learning, memory, and rational planning. Development of these aspects of the personality facilitate the experience of pleasure and satisfaction.

Freud had moved the focus from the external trauma to an emphasis on the internal workings of the mind within the topographical model, and back again in the structural model. Hartmann moved structural theory further reality-wards in viewing pleasure not only in terms of satisfaction of instinctual wishes, but also on what good experiences the external world was in reality able to afford.

A further contribution of ego psychology was the distinction between Freud's view of the ego as an impersonal "structure", and a more experiential take on the ego as a *manifestation of the self* – a view developed by Kohut in self-psychology. In the European version of ego psychology, Anna Freud (1936) emphasised the importance of the relationship between the ego and the external world, and the normal and adaptive aspects of the personality. She considered defence mechanisms as responding not only to the dangers of the internal world but also – for example, in "identification with the aggressor" (see Chapter 4) – to the child's developmental environment.

Her approach was less strict in its adherence to the structural model than that of the ego psychologists, and she continued to emphasise the usefulness of the topographical model. Overall, ego psychology in general has gradually become more integrated with object relations theory (Wallerstein, 2002), with its traces still evident in the work of Kernberg (1976, 1980), Gill and Hoffman (1982), Arlow (1985, 1991), and Sandler (1987), for example.

The Klein–Bion model

Although primarily a clinician rather than a theory-builder, it is generally agreed that Melanie Klein was one of the most original and challenging thinkers in the history of psychoanalysis. Klein saw that, for all its advantages, something had been lost in the move from the topographical to the structural model, especially the notion of *unconscious phantasy* within intrapsychic life. By focusing on early pre-oedipal experiences Klein hoped to reinstate phantasy in the psychoanalytic conceptual and clinical vocabulary.

The Kleinian "positions"

Klein is perhaps best known for her account of the two basic "positions" of mental life – the "paranoid–schizoid" and the "depressive" – and for her notion of "projective identification" (see Chapter 4). Brown (2010) outlined Klein's "positions" as constellations of phantasies, anxieties, and defences mobilised to protect the individual from internal destructiveness. In the paranoid–schizoid position the focus of the anxiety is on threats of annihilation and disintegration. The infant attempts to organise these experiences through splitting and projection (see Chapter 4), as "bad" experiences are split off and projected into the object. This stabilises and protects the fragile infantile self, but means that the object is now felt to be persecuting and dangerous and a potential threat. Good experiences may also be projected into the object for "safe keeping", which then becomes idealised.

In the subsequent depressive or "reparative position" (Carveth, 2018), anxiety is not so much about the survival of the self, but the survival of the object on whom one depends. The individual realises that the frustrating and hated object is the very same one that satisfies and is loved and loving. This realisation fuels ambivalence and guilt. Although Klein's "positions" are schematic and seemingly mutually incompatible, in everyday life there is a constant oscillation between the two, and a third "borderline" position has also been described (see Chapter 10).

Phantasies and drives

For Freud, libido and aggression were structureless phenomena whose form is dictated by developmental bodily stages as well as by drive gratification/

frustration. But, for Klein, the instincts are inherently attached to objects, as pre-formed "primary phantasies". The basic unit of mental life therefore becomes an object-related unconscious phantasy, rather than instinctual wishes that seek expression through "self-created" objects. For Klein, the unconscious has specific contents right from the start of mental life – that is, unconscious phantasies such as the good, gratifying, and loving "breast" – which are the mental corollaries or the psychic representations of instincts. An instinctual wish can only be *experienced* as an unconscious phantasy (Isaacs, 1943).

There is a continuing psychoanalytic debate about the degree of innate knowledge possessed by the infant, and the extent to which unconscious phantasies are formed throughout development. For Klein, destructiveness and unconscious phantasy are innate and "primary", and thus "the infant has an innate unconscious awareness of the existence of the mother…" and this forms "…the instinctual knowledge that is the basis of the infant's primal relation to the mother" (Klein, 1957). This concept of a pre-programmed thinking infant, as opposed to Freud's *tabula rasa*, has received some confirmation from developmental psychology, although Stern's (1985) picture of happy infant–mother attunement is a far cry from Klein's model of primary envy and hatred (cf. Chapter 3).

Bion and containment

In Freud's early writings, "the object" appears only as the provider or withholder of gratification, although by the time the oedipal stage is reached, objects are fully formed mothers and fathers. Freud never spelled out in detail how the infant moves from drives to relationships with people in the space of 3 years. Klein tried to reconcile drive theory with object-finding in her notion of the primary object, but it was Bion, her analysand, who moved Kleinian theory decisively away from drives and towards relationships. In his concept of "*container and contained*", Bion (1962) extended and normalised the idea of projective identification (see Chapter 4), showing how the mother's role as prototypical caregiver is to contain her infant's projected feelings of pain, fear of death, envy, and hatred (and perhaps excitement and joy). These feelings are "detoxified" by the nurturing (or, in the case of analysis, "listening") breast, and then returned in such a way that the infant receives good feelings of being held and understood, rather than bad projections. In this way, the infant makes sense of his experiences, and introjects an object that is capable of bearing and allaying anxiety.

Object relations theory

Bion moved Kleinian thinking into the realm of object *relations* rather than objects *per se*. We have suggested that psychoanalytic theorists may be divided into those who focus primarily on the internal world (Klein), those who focus more on the external world (the "Neo-Freudians" – Sullivan, Fromm, Horney, Erikson, and Bowlby), and authors who lie somewhere between the two (Winnicott, Bion, and Kohut). A further distinction may be made between object relations models that incorporate drive theory and those that do not. Fairbairn, Guntrip, and Sullivan made no such attempt, whereas Mahler (see Chapter 3), Klein, Kernberg, and Kohut tried to do so, although the latter, as we shall see, downplayed aggressive drives. British writers, such as Winnicott, Balint, and Sandler, have had no difficulty in combining the two, especially in their clinical formulations. Fairbairn (1952a), Guntrip (1961, 1974), Winnicott (1953), and Balint (1937) tend to be seen collectively as "the British object relations theorists" (Greenberg & Mitchell, 1983; Phillips, 1989). Although their contributions vary, they share a number of pivotal assumptions (Westen, 1990).

Object seeking

Central to the theory of object relations is the belief that a person's primary motivational drive is to seek a relationship with others. The infant's early activity is directed towards contact with the mother: "pleasure is a signpost to the object, rather than vice versa" (Fairbairn, 1952b) – that is, we are primarily object seeking rather than pleasure seeking, and the end goal is the relationship with another person, who provides security and comfort as well as need satisfaction. The method of object seeking varies according to the stage of development: initially through feeding and mutual gaze (Gergely, 2007; Wright, 1991) and later through the sharing of activities and interests. This does not completely overthrow the concept of pleasure seeking, since, as Balint (1957) sensibly says, the individual is both object and pleasure seeking. The compulsive quest for pleasure may also be a psychopathological response when object relationships fail.

The representational world

The core notion of object relations theory is that of an *internal world* populated by the self, its objects, and the relationships between them. This is Sandler's "representational world", which he likened to a proscenium stage upon which the scenes and dramas of inner life are enacted. The relationships between these internal objects act as templates for subsequent relationships, especially when the primary processes are activated. Intimate relationships with partners and with the analyst will be profoundly

influenced by the contours and valencies of this internal world. However, in contrast to Klein's idea of primary object phantasies, Fairbairn (1952b) conceived of internal objects and the phantasies associated with them arising as a consequence of the unavoidable "failure" of external objects to gratify our every need. For him, this leads to a split at the heart of the psyche between the "libidinal object", which gratifies, and the "anti-libidinal object", which frustrates. These objects are associated with corresponding libidinal and anti-libidinal self-representations. In Fairbairn's schema, aggression is a primary organising factor, secondary to these frustrations. He also stressed that what is internalised is not an object as such but a relationship.

Transitional space

Winnicott [for discussion of his work, see Phillips (1988), Abram (2007), and Abram and Hinshelwood (2018), for example], himself one of the most creative if sometimes gnomic psychoanalytic theorists, famously saw creativity and a robust internal world as resulting from the "good-enough" mother–infant relationship. For Winnicott, object relations theory encompasses not just internal and external objects but their mutual interplay. This he located in "transitional space" – neither inside nor outside, but in between.

Transitional phenomena are the missing link between Freud's pleasure principle and the reality principle, and Winnicott's (1965) effort to reconcile drive theory with an interpersonal perspective. He believed the drive-driven child conjures up in his mind an "object" suited to his needs, especially when excited. At this precise moment, the "good-enough" mother presents him with just such a suitable object, complementary to his wish. In this moment of "illusion" the baby feels that he has "made" the object himself: "Want breast"; breast appears; "I can make a breast appear". The repetition of these "hallucinatory" wishes and their embodiment (realisation) by the mother leads the infant to believe he is the author of his own world. This healthy omnipotence underpins the emergence of a creative and playful self. Once this "true self" has been established, omnipotence needs to be gradually abrogated and the realities of pain, separation, helplessness, and loss faced. Gradually, the developing infant comes to differentiate between reality and phantasy, realising that there is an outside reality independent of one's own projections. A secure sense of self and other and their mutual relationship begins to crystallise out.

In Winnicott's model of psychopathology, caregivers who are consistently neglectful, inattentive, self-preoccupied, depressed, or controlling lead the child towards a compliant "false self", thwarted creativity, and repressed instinctual drives and relational longings. Guntrip (1961) believed that *regression* into the transitional space of the analytic relationship re-establishes the movement from

healthy omnipotence to depressive position "good-enoughness". Balint (1968), as discussed by Sklar (2017), also emphasised the importance of regression as a therapeutic tool in the analysis of disturbed or "basic fault" patients (i.e., those with borderline pathology).

Hate

Just as Winnicott tried to reconcile phantasy and reality in his notion of transitional phenomena, so in his concept of *positive hatred* he tried to relationalise the death instinct. In his paper *The Use of the Object* (Winnicott, 1969), he distinguishes between two types of experience, which he calls "relating to the object" and "using the object". Confusingly, "using" here does not imply exploitation as it does in vernacular parlance, but rather a mature relationship to people and things in which they can be interacted with and transformed. This positive "use" depends, in Winnicott's model, on the simultaneous mobilisation of creative destructiveness (new beginnings entail jettisoning the old), and the capacity of the "object" (i.e., the caregiver) to survive such hate and remain intact. Initially, the object is seen as an extension of one's own mind, neither real nor separate from the self. Later, a different type of relationship emerges, based on joint attention, shared reality, and a degree of mutual "mentalising" (a term that post-dates Winnicott).

Winnicott saw the driving force behind these developments as "hatred". For the object to be recognised and experienced as outside the person's control, it has to be destroyed in phantasy – but then experienced as surviving in reality. This healthy hatred is conceptualised not so much as a damaging force as an integral and necessary part of the separation–individuation process: "Hello object! I destroyed you" (Winnicott, 1969). Winnicott's theory is consistent with the evidence from neuroscience that securely attached mothers tolerate their infants' unhappiness and crying with equanimity compared with their insecure counterparts (Strathearn, Fonagy, Amico, & Montague, 2009).

Winnicott's creative synthesis of the drive-based and relational models did much to prevent an ossification of theoretical views within the British Psychoanalytical Society. However, in the United States, many psychoanalysts began to chafe at the rigidity of ego psychology, seeing its exclusive emphasis on the oedipal situation and instinct as limited and limiting. Furthermore, in the 1960s, there was a cultural shift leading to an interest in the self, both positively, as an arena of personal liberation, and negatively, as a withdrawal from relationships into self-aggrandisement and self-gratification. Within psychoanalysis, these two factors crystallised in Heinz Kohut's self-psychology. According to Lasch (1979) and Schafer (1977), this represented a shift in theory from thwarted instinctual gratification to a concern for self-fulfilment, a move from guilty "oedipal man" suffering from internal conflicts to "tragic man" struggling with problems of cohesion and

the very integrity of the self. In addition to its reaction against the orthodoxies of ego psychology, self-psychology has its roots in the interpersonal model put forward by Sullivan (1962).

The interpersonal model

The interpersonal model, developed by the so-called Neo-Freudians – Sullivan (1962, 1964), Horney (1939), Fromm (1973), and Erikson (1963) – takes a radically relational stance. To paraphrase Winnicott, for the interpersonalists, "there is no such thing as an individual". Sullivan was a psychiatrist who became convinced that the strict Kraepelinian view of schizophrenia in the 1920s was wrong in seeing the illness as a biologically determined, irreversible deterioration of the personality leading to complete breakdown of mental and emotional functioning. Well ahead of his time, he realised that many of the features of "schizophrenia" were the result of institutionalisation, rather than disease process. He argued for stimulating human relationships and not just custodial care.

In common with other psychoanalytic views, the interpersonal model emphasises early mother–child interactions as central to the subsequent development of the personality, but does not see the child's internal world as the determining influence. Instead, the drive-structure model put forward by Freud is reversed. Anxiety, rather than arising from unconscious instinctual wishes pushing for expression and satisfaction, is seen as stimulated from outside, a response to the state-of-mind of the other. The child forms specific mental representations according to the anxiety that is engendered and imagines that a "Bad Me" has elicited anxiety in the (m)other. In the same way, a "Good Me", which alleviates anxiety, is also set up, alongside a "Not Me". The latter is a response to severe panic and confusion, akin to Guntrip's vulnerable helpless self, or Bion's void at the core of the schizoid mode of being, forming a nucleus for subsequent psychotic fragmentation.

Anxiety-laden experiences are elaborated into stable, albeit restrictive, interpersonal strategies. These "security operations" include avoidance, inattention, tactical misrepresentations, and other interpersonal and at times malign or self-defeating manoeuvres. Sullivanian interpersonal psychoanalysis also contributed to a significant technical shift away from "reconstruction" to a focus on the here-and-now in the analytic situation. The interpersonal approach was clearly a reaction to the esotericism of psychoanalytic theory, and encouraged a less theory-laden, more collaborative relationship between patient and analyst. Transference was now seen primarily as an intensified slice of life, rather than a distortion of the present by complex phantasies about which only the all-seeing analyst has expert knowledge.

Interest in Sullivan's interpersonal approach was revived in the 1980s as another post-Freudian school, relational psychoanalysis, emerged, based around its own journal, *Psychoanalytic Dialogues*. Key figures in the

relational movement include Mitchell (2000), Aron and colleagues (Aron & Leichich, 2011), Benjamin (2004), and Bromberg (2011, 2014). As in Sandler's "present unconscious", the emphasis in relational psychoanalysis is on the here-and-now relationship between therapist and patient and the mutuality of their unconscious communications and resulting dialogue. Relational psychoanalysis is controversial in its critique of analytic reticence and neutrality, and its validation of limited analyst self-revelation in sessions. This has the positive benefit of enhancing patients' trust and confidence in their analysts, but may militate against the crucial analytic tool of transference, which depends on a degree of analytic ambiguity.

Self-psychology

Kohut (1971, 1977) challenged psychoanalytic orthodoxy in the United States, claiming that a new approach that went beyond oedipal analysis was needed if patients with narcissistic disorders, who were becoming increasingly common, were to be successfully treated. The focus of his theory became the "self", and the effect that denial, frustration, and fulfilment of wishes has on its development. At first, Kohut tried to build on both object relations theory and ego psychology, and portrayed the self as arising from mental representations within the ego. Later, he came to depict the self as a supraordinate structure with its own developmental line, which subsumed instinctual wishes and defences.

Necessary narcissism

Just as in ego psychology Hartmann had postulated a "conflict-free" zone of the ego, Kohut built on Freud's notion of "primary narcissism" (see Chapter 3). He suggested that self-love was necessary for psychological health, with narcissistic *disorders* resulting from defects in the self brought about by parental empathic failures. He postulated first a "bipolar" self and later a "tripolar" self, whose poles are self-assertive ambitions, attained ideals and values, and talents and skills. Pathology may arise from a disturbance at each pole and may be compensated for by strength in one of the others.

The idea of the narcissistic self following a separate developmental pathway can be seen as an expansion of Anna Freud's (1965) notion of separate developmental lines along drive-, ego-, and object-related pathways. However, the view that the self is a supraordinate or unifying, overarching vector in personality development is more controversial. The main point of contention is Kohut's view that aggressive drives are secondary, arising from an insufficiently consolidated self brought about by empathic failures. Kernberg (1975, 1984) in particular has called attention to this de-emphasis on the aggressive drives. It is also difficult to see in Kohut's schema where the superego fits as an organising focus, if ideals and values are seen as parts of the self.

A central contribution of self-psychology is the idea of the *self-object*. This is one's subjective sense of a sustaining intimate relationship with another whose security and interest maintains the self. "Self-object needs" were initially described in the treatment of narcissistic patients, but are now considered to be ubiquitous and enduring, and part of the normal psychological functioning of the self. Self-object needs lead to "self-object transferences" (see Chapter 5), comprising mirroring, idealising, and twinship transferences, each corresponding to a different pole of the tripolar self.

The term "self-object" has come to be used in a generic fashion to describe the role that others perform for the self in relation to mirroring, idealising, and twinship needs. These needs are never fully outgrown, and self-objects are best viewed as continuing aspects of others needed to meet the psychological needs of the self, such as security, soothing, admiration, and so on. This viewpoint differs markedly from the drive-structural and object relations views, which emphasise the importance of separation–individuation as the essence of maturity. In self-psychology, the focus is on the need for empathic and affirming responses from others throughout life, but with a move from reliance on archaic objects towards mature dependency (Fosshage, 2003).

Attachment theory

Attachment theory emerged in the 1950s and 1960s, in part as a result of John Bowlby's reservations about a number of aspects of the psychoanalysis in which he had been trained. These included the lack of cross-fertilisation with other related disciplines; the de-emphasis of the role of environmental difficulties and trauma in precipitating and perpetuating psychological illness; the absence of scientific evaluation of its hypotheses; and over-valuation of interpretation as the mutative ingredient in psychoanalytic therapy, as opposed to the more generic aspects such as the therapeutic relationship.

Attachment theory does not purport to offer a comprehensive "model of the mind", but emphasises an aspect generally downplayed in mainstream analytic theory: the need, throughout life, for emotional and physical proximity to a significant other or secure base, especially when ill, threatened, or tired. The attachment dynamic is thus an aspect of the "behavioural immune system", whose function is protection and security. Although there was initial *froideur* among analysts in response to Bowlby's work, there are now a number of authors who have forged a partial reconciliation (Eagle, 2013; Fonagy & Target, 2007; Holmes, 2013; Holmes & Slade, 2018; Slade, 2016).

Conclusions

Each developing analyst has to struggle with the tension between conservatism and innovation within the analytic tradition. At one extreme,

there is a desire to overthrow parental authority and define a new territory of discourse; at the other, there is a determination to preserve what is good in the old. These extreme "oedipal" reactions, while necessary in exceptional circumstances and for exceptional thinkers, are not part of "normal science" (Kuhn, 1962). The developing analyst is first in the position of an oedipal child who has to negotiate both healthy identification and separation in the course of his intellectual development, and later is in a parental position, having to reconcile, as far as possible, the different voices of the competing analytic factions. As Gabbard and Ogden (2009) epigrammatically put it, the task of post-qualification analysts to find their own voice entails both "honouring the ancestors" and "killing the father".

Self-psychology's emphasis on empathy, positive narcissism, and challenge to a drive-based interpretive analytic stance was a necessary counterweight to the excesses of ego psychology. Indeed, virtually all the theories discussed in this chapter developed because of dissatisfaction with aspects of a prevailing model.

Freud's language, influenced by the physics of his day, lives on: psychoanalysts still speak of object, drive, and their mutual "dynamics". At the same time, in the contemporary search for a unified theory, three themes stand out: *representation*, *affect*, and *narrative*. For Sandler (1981), self and object representations are what guide the individual in his or her relationship with the external world. Sandler suggests that the primary motivational element is the regulation of feeling states to maintain a sense of security, rather than drives. Similarly, Stolorow, Brandchaft, and Atwood (1987) have argued that the notion of endogenous drives should be abandoned and replaced with affects as motivational elements formed within the interaction between self and self-objects.

In affect theory, meaning intersects with mechanism. Meanings are a way of organising problematic emotional experience into coherent narratives, which stabilise the self's relationship to its world (Elliot & Shapiro, 1992). The focus of interpretive work is no longer on instinctual conflicts, frustration of wishes, or aggressive drives, but on the patient's affective experience, its repetition within the analytic relationship, and the translation of that experience into coherent stories or narratives that make sense and act as guides and warnings for future action. Pine's (1981) emphasis on the importance of "intense moments" and the Boston group's "mutative moments" (Stern et al., 1998) during both development and treatment exemplify this.

However, just as psychoanalysis sees the personality as "a precipitate of abandoned object cathexes", so changes in theory and practice often have their precursors. For example, a focus on the affective experience is not new. Fenichel (1941) summarised the problem of resistance as either an intense affect, such as rage or erotic arousal, obfuscating cognitive awareness of unconscious conflict, or the reverse, intellectualisation as a defence against

affective experience. Too great a reliance on either cognitive or affective experiences impoverishes the understanding of the complexity of human motivation and interaction, and loses the unity of affect and cognition.

Psychoanalytic models of the mind remain in a state of development and intellectual tension. Some theorists and clinicians have argued the need for a "new paradigm" in the psychological sciences arising out of, but going beyond, current psychoanalytic thinking. If psychoanalysis is to remain a relevant and living discipline, it must open itself up to findings in related disciplines such as child development (Fonagy, 2002), neuroscience (Holmes, 2020; Solms, 2018a), linguistics (Fonagy & Allison, 2014; Talia et al., 2019), and cognitive science (Bateman & Fonagy, 2019). Similarities, differences, and contradictions both within and outside psychoanalysis must be accepted and, where possible, worked through to a new synthesis.

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Chapter 3

Origins of the internal world

> To our surprise we find the child, with its impulses still living on ... (Freud, 1900, p. 191)

Freud was a Darwinian. He saw in the adult mind vestiges of its evolutionary and developmental history, and believed that psychological illness could best be explained by tracing back neurotic symptoms to their childhood origins, hence his famous aphorism, "hysterics suffer mainly from reminiscences" (Freud, 1895b, p. 7). He was also influenced by the ideas of the British neurologist Hughlings-Jackson (as discussed by Sulloway, 1979) who argued that in illness the nervous system reverts to more primitive modes of functioning.

For Freud then, as for Wordsworth, "the child is father [sic] to the man". The clinical implications of this are twofold. First, it suggests that many of our fears and phantasies, doubts and difficulties, are relics of earlier phases of life, anachronistic in the adult world. Second, it helps us to be more aware and tolerant of the "child within" (Sandler, 1992) that lives on in the unconscious mind and continues to influence adult thoughts and actions.

In this chapter, we consider psychoanalytical theories about how the features of healthy adult psychology that we take for granted – a secure sense of self, stable self–object differentiation, the capacity for both intimacy and aloneness, a regulated and modulated emotional life, self- and other-awareness, good-enough self-esteem – emerge from the undifferentiated states of infancy. We look, too, at how adult difficulties in these areas have their roots in the developmental processes of early mental life. Before doing so, we must consider some overall themes relevant to the theoretical approaches discussed in the previous chapter.

"Stages" versus phases

In his early writings, Freud (1905) saw psychological development as passing through a series of "stages" – oral, anal, phallic, and genital – which

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individuals traverse on their way to maturity, with pathology arising from "arrest" at one or other stage.

Contemporary psychoanalysis has modified this model in a number of important ways. First, each stage cannot be equated with an organ or "erotogenic zone" in the simplistic way that was originally conceived. Observing the handling and mutual gaze of mother and infant is enough to convince the observer that the newborn infant's world is as much tactile, olfactory, and visual as it is "oral". The preoccupations, aspirations, and fears of the "phallic" 3-year-old can be seen in only the most tenuous way as centring around pleasure and pride in the possession of, or fear of losing or having lost, his or her genitals. Second, therefore, Freud's "zones" are perhaps better seen as a shorthand or metaphor for different existential *themes* that preoccupy a child at different stages of his or her development. Erikson's (1963) stages – trust versus mistrust, autonomy versus shame, initiative versus guilt – each capture a fundamental issue that reflects a child's attitude towards the world rather than the predominance of a particular part of the body.

Third, the idea of specific "stages" as confined to defined age bands is questionable. For instance, the "anal" phase is often characterised as occurring in the second year of life and to reflect the child's developing capacity for control and ability to resist parental impositions. But, as Stern (1985) points out, a child can say "No!" at 4 months by gaze aversion, at 7 months with gestures, at 14 months by running away, and at 2 years verbally.

A contemporary framework for thinking about psychological ontogeny includes the following:

1. Development is not predetermined, but is shaped by the interactions between the child and his or her interpersonal world.
2. There are different possible developmental pathways, only some of which will unfold in any particular environment.
3. Freud's "stages" remain potentially active as developmental lines throughout life, which may be activated at times of stress.
4. The impact of environmental trauma can throw the developmental process off course at any stage in the life cycle, while good experiences in early life have a buffering effect (Westen, 1990).
5. Maturational processes continue throughout the life cycle. The adolescent psyche (and brain) modifies and reworks earlier developmental themes and, as Jung (1916) believed, the second half of life also entails major new challenges.

Example: The woman who could not trust

Martha came into therapy when she became deeply distressed on discovering that her husband was, as she put it "a compulsive liar". He lied not just about his affairs, but had created a whole tissue of deceit about his past and present activities. Formal and correct in her manner, and slightly distant, she recalled a childhood dominated by waiting for her father to return from the war. "He will soon be back", she was told, as she sat at the window waiting and watching – but he never did return. He was dead, and her mother and grandfather who brought her up knew it. She had never discussed this with her mother, even at the very end of her mother's life. Martha's relationships, including that with her analyst, were typified by a mixture of naive trust and emotional withdrawal.

Here, we see how a "relationship theme" – the betrayal of trust – can permeate a person's life as a developmental line, forming a focus for analytic work. For Martha, the links stretched from the "untrustworthy" father who never came home, to the faithless husband; and backwards, by inference, to her earliest relationship to a mother who, grief-stricken in her denied and therefore unmourned widowhood, was unable to respond sensitively and trustworthily to her baby's needs. All this, the analyst predicted, would be played out in the transference, as he was seen through the lens of her untrusting scrutiny.

The origins of internal objects

Freud (1915) assumed that the infant has "primal phantasies" – that is, phylogenetically inbuilt knowledge of parental intercourse (the primal scene), castration, and oedipal seduction. Klein (1952) and Isaacs (1943) extended this idea, arguing that infants have pre-formed knowledge of the "breast", "penis", "urethra", and so forth, which shapes and guides their early and subsequent experiences. Thus, the phantasy of the internal object relation, "breast-in-mouth", becomes a prototype for all incorporative activity, whether nutritive, sexual, or the taking in of knowledge. In this view, the nature of the "internal object" – the child's representation of their quintessential "other" – is primarily intrapsychic, gradually modified by the behaviour of the actual object in question. Phantasies continue to influence mental life in adults as well as children, every thought having unconscious as well as conscious ramifications and reverberations.

However, Freud also realised that internal objects were not just inborn but, via identification and internalisation, also reflect the specific relationships that

permeate a person's early years. Thus, "The shadow of the object fell upon the ego" (Freud, 1917, p. 249) and "The character of the ego is a precipitate of abandoned object cathexes and it continues the history of those object-choices" (Freud, 1923, p. 63). His idea of the superego as an internal representative of parental prohibition is the most striking example of this. In contrast to the primal phantasy intrapsychic model, Fairbairn (1952b), Bowlby (1988), and relational psychoanalysts (Mitchell & Aron, 1999) adopt an interpsychic approach, in which the internal world is shaped by the actual behaviour of the object – how loving (versus depriving) the breast, how threatening a paternal prohibition, and so forth. Padel (1991) points out that what is internalised is not an "object" (a "mother" or a "penis") but a *relationship*, and that the individual, via role reversal, may identify with either "end" of this relationship – thus, in the familial intergenerational transmission of abuse, the abused child in one generation may become the abuser in the next.

Bion (1962) takes a middle position, giving weight to both intrapsychic and interpsychic factors, envisaging the behaviour of the caregiver rather like an ethological "releaser" of inherent mental structures. He sees the nurturant function of the "breast" as having the capacity, not necessarily realised, to turn a potential thought within the infant (in his terminology, a "pre-conception") into an actual phantasy or internal object (for Bion, a "conception"). This model can be compared with Chomsky's (1965) view of the development of language in which a "deep structure" or potential for speech (the Language Acquisition Device) becomes a specific dialect depending on the prevailing linguistic world in which the child is immersed. Comparably, the psychoanalytic child could be said to possess a "Phantasy Acquisition Device". The clinical relevance of this would be a therapist using his "breast-mind" to elicit previously unexplored developmental pathways in the mind of the patient.

The nature of memory

Also relevant to this discussion is how memory is conceptualised. Freud's "reminiscences", which are the raw material of much psychoanalytic work, can be thought about in a number of different ways. Tulving (1985) distinguishes between (a) "procedural memory", a non-verbal representation of how we were handled as an infant, akin to Klein's (1946) notion of "memories in feeling"; (b) "semantic memory", the patterns of interactive behaviour or "scripts" (Byng-Hall, 1991) that reflect the child-rearing patterns and family culture in which we were brought up; and (c) "episodic" memory, actual recallable episodes, or events.

Although few have episodic memories before they were 2 years old, early relationship patterns continue to influence the way we experience and relate to the world ("semantic" memory). From a psychoanalytic perspective, the

clues to these are their manifestations in the transference. Just as the behavioural manifestations of sexual love contain vestiges of infant behaviour – mutual gazing, touching, sucking, intense separation anxiety/sadness, and so forth – so phantasy continues to shape adult mental life, especially at times of emotional intensity. In health, this enhances and deepens emotions: musicians may be observed making primitive sucking movements with their lips while playing at the highest sublimity. In psychological illness, the sufferer's "primitive" emotions are often easily triggered, unmodulated by cognitive appraisal. These emotional responses may come transferentially to the fore in an anachronistic way. A therapist might calmly announce that she will unavoidably have to miss a session. An instant response from someone whose childhood included fostering by multiple caregivers might be an angry or sarcastic "Oh, *I see* you just can't wait to get rid of me".

Relevant here is Freud's concept of "nachträglichkeit", variously translated as "deferred action", "afterwardness", or, in French, "après-coup" (Perelberg, 2006). Nachträglichkeit could be seen as an expression of Kierkegaard's famous aphorism that "life is lived forwards, but understood backwards". Psychoanalytically, the point is that the meaning and significance of a remembered event is shaped as much by a person's state-of-mind in the present as it was at the time of the occurrence. Freud saw the unconscious as unconstrained by chronological time, so that the flow of time can be bidirectional: "The traumas of childhood operate in a deferred fashion as though they were fresh experiences; but they do unconsciously" (Freud, 1896, p. 354). Thus, childhood sexual abuse, which might have had elements of elusive comfort at the time, is in retrospect experienced as shameful and abusive. This fluidity of memories now has neuroscientific support (Gorman & Roose, 2011) in that there is evidence that when an event and its emotional accompaniment is recalled it can either be "reconsolidated" or disconfirmed and so "deconsolidated".

This is relevant to the paradox of transference, in which the past is "repeated" but also challenged as a novel experience; for example, caring sensitivity disconfirms memory-based expectations of neglect or abuse. "Deferred action" here is a kind of reverse transference in which past memories are available to be revised in the light of present circumstances. In its positive forms, this "updating" process is what makes psychoanalysis possible and effective.

Nachträglichkeit in its extreme forms may even create *apparent* episodic memories, contributing to "false memory syndrome" (Pope, 1996), in which therapists and their clients collusively (evading oedipal "triangulation" and/or mentalising the phantasy–reality boundary) take as fact supposed memories of maltreatment that in fact lack corroborative evidence (Birksted-Breen, 2003). As Stern (1985, p. 46) puts it: "Development is not a succession of events left behind in history. It is a continuing process, constantly updated".

The "clinical" infant and the "observed" infant

Finally, infancy has, until recently, been something of a *tabula rasa*, a blank screen on which theorists, not excluding psychoanalysts, have projected their preoccupations and ideologies. It is only with the emergence of detailed observational studies of early infant–parent interaction that the observed, as opposed to the clinical, infant (Music, 2017; Stern, 1985) has been able to "speak back" to its theorists and to correct some of the misconceptions that have been heaped on it.

With these preliminaries in mind, we shall now turn to the psychoanalytic account of psychological development, working chronologically from birth.

Two-person phase: defence or deficit?

For Freud (1916–1917), the three-person Oedipus complex was the "kernel of the neuroses". In the early days of the psychoanalytic movement, a belief in the centrality of Oedipus was a hallmark of psychoanalysis, an unquestionable dogma, so that when Melanie Klein, building on her analyst Abraham's developmental schema, turned her attention to the early months of life it was natural that she should call them "pre-oedipal". Balint (1952), however, following Rickman (1950), introduced the more neutral terms "two-person" and "three-person" stages.

This debate has important consequences beyond terminological disagreement. As we saw in Chapter 2, Freud's model was essentially based on *conflict*. For him, neuroses derive from the incompatibility of the demands of civilisation on the one hand and those of the instincts on the other, and the tension between the desire for exclusive love from parents balanced against the fear of rivalry, and its consequences, this arouses. Freud emphasised the ubiquity of unconscious incest-wishes, and saw primal repression as the means by which these wishes must at all costs be kept from conscious awareness.

Kernberg (1984) and Kleinians such as Segal (1986) extend this conflict–defence model back into infancy, where there is still a struggle between the love infants have for their caregivers and the hate they feel at the caregivers' absences and failures to respond instantly to their demands. Others, notably Kohut (1977) and Winnicott (1965), saw the problems as based on *deficiency* – the lack of vital ingredients needed for healthy development, especially maternal empathy and sensitivity. Both defence and deficiency models can help to understand psychological illness and its psychoanalytic amelioration (see also Chapter 11).

The early weeks of life: "autism" or symbiosis

Freud compared the psychic state of the newborn with that of an unhatched chick: "a psychical system shut off from the stimuli of the external world, and

able to satisfy even its nutritional requirements autistically...” (Freud, 1911, p. 218; Hamilton, 1982). This led Mahler, Pine, and Bergman (1975) to describe a stage of “normal autism”, and Freud (1914) to his controversial concept of “primary narcissism”, the non-conflictual self-love which precedes the capacity to love others, based on the blissful self-absorption of the newborn.

For Mahler, the first 6 months of life proceed from “normal autism” through “symbiosis” to “hatching”. However, the use of the term “autism” in this context is questionable (see Tustin, 1986, 1994 for a contrary view, later retracted). Newborn infants are certainly self-centred, but they participate very actively in the two-person environment and, for example, are able to distinguish their mother’s voice, smell, and face from others’ within days of birth (Music, 2017). Two-week-old babies are active mimics, accurately mirroring caregivers’ tongue protrusions. This leads to a two-person picture of mother–infant *symbiosis*, or “biobehavioural synchrony”, fuelled by the infant’s need to reach out to a nurturing figure, and the responsiveness – physiological, via oxytocin, and psychological – of the sensitively attuned mother (Feldman, 2015).

For Freud, primitive feelings of “goodness” were related to “primary narcissism”, the necessary state of self-love that we all need to survive, “autistic” only in the sense that, as Slavin and Kriegman (1992) put it, “because we are members of a sexually reproducing evolved species, nobody loves us as much as we love ourselves”. Freud (1914) saw this “narcissistic” self-love as developmentally prior to “anaclitic”, “leaning on”, or object love, a theme developed by Blatt, Zuroff, Hawley, and Auerbach (2010). In Freud’s famous “amoeba metaphor”:

> ...an original libidinal cathexis of the ego, from which some is later given off to objects, but which fundamentally persists and is related to object cathexes much as the body of an amoeba is related to the pseudopodia which it puts out. (Freud, 1914, p. 75)

Freud visualised this primary narcissism persisting into later life in the form of the “ego ideal”, which informs our aims, values, and ambitions, later coalescing into the superego; and in the narcissism of parental love, which makes one’s own children special above all others:

> His majesty the baby ... parental love which is so moving and at bottom so childish, is nothing but the parent’s narcissism born again. (Freud, 1914, p. 90)

The Klein–Kernberg model of early infancy

For Freud, the newborn baby’s mind is pure id, lacking an ego with which to relate to the world. Klein disagreed. She saw a primitive ego, and therefore

primitive object relations, as present from birth. In her binary affect model (see Panksepp & Solms, 2012, who identify seven primary emotional constellations, for related discussion), the infant encounters and introjects two sets of contradictory experiences: "good", satiating, nurturing feelings associated with successful feeding, warmth, and tactile contact; and also "bad" experiences – separation, abandonment, hunger, wetness, and cold. These coalesce to form the nuclei of fundamental feelings of love and hate, desire and aggression, attraction and aversion, eros and thanatos, the life and death instincts.

In the Kleinian account, the primitive ego maintains psychic equilibrium by keeping good and bad apart. The infant introjects and identifies with the "good me" experiences, while splitting off the bad "not me" feelings and projecting them outwards into the nurturing parent, whose "good breast" becomes temporarily transformed into a "bad", persecutory one. In this omnipotent and potentially psychotic state in terms of mental boundaries, all is magically personified. As opposed to the vicissitudes and randomness of reality, "everything is the result of the actions of objects" (Etchegoyen, 1991). Further anxiety now ensues because, to get good experiences "in", the child has to "cannibalise" (i.e., introject) the parental goodness. But the child now feels he has doubly "destroyed" the breast – via the need to expel badness and by his voraciousness – and this destructiveness also has to be projected, leading to another spiral of the vicious circle. Ultimately, these dilemmas are resolved in the depressive position, where good and bad coexist; reparation means that we take responsibility for, and creatively transcend, our destructiveness; we are able to accept loss, mourn, and relinquish guilt.

In the Kleinian model, this good/bad "splitting" is a necessary defence, enabling a core sense of self-worth and goodness to hatch, uncontaminated by feelings of rage and disappointment. The attuned parent, or receptive breast, allows these bad feelings to lodge safely until they can be reintegrated in the infant's nascent depressive position. But if this detoxifying function of the breast is unavailable – due to neglectful, inconsistent, or abusive parenting, and/or if the bad feelings are excessive and cannot be reintegrated – splitting can act as a brake on development. The clinical implications of this mean that the analyst must judge whether splitting needs to be left uninterpreted (the "containing" function), at least initially, or whether negative transference must be faced and interpreted from the start. Kernberg (1984) tends to advocate the latter, but Joseph (1989, p. 76) cautions:

> When analysts ask their patient to face their fears, their yearning, their sadness long before they have the resources and imagination to do so, they may be asking too much.

In sum, in the "paranoid–schizoid position", the Kleinian child trails clouds, not so much of glory, but of envy, rage, and disappointment. Klein envisaged

this state balanced by the "depressive position" in which good and bad, love and hate come together as the child comes to realise that the hated and feared object is the very one he loves and depends on. Klein believed the interplay between these two positions continued throughout life, especially at the major crisis-points of psychological development.

Interpersonal models of early infancy

In contrast to the Kleinian model, relational perspectives (Mitchell & Aron, 1999) start from a two-person matrix of infant and parent, out of which eventually crystallises a sense of an autonomous, separate self. Winnicott (1965) and (Stern, 1985) see this stable sense of self arising out of parental "handling" based on maternal sensitivity and attunement. For Winnicott, *holding*, *integration*, and *personalisation* are the key issues (Dias, 2016). Holding starts before the birth with *primary maternal preoccupation,* in which thinking about the baby comes to assume increasing salience in the mother's conscious and unconscious mind. The child is thus a *recipient* of parental projections as well as a source of projection. Fraiberg, Adelson, and Shapiro (1975) evocatively call these "ghosts in the nursery" – that is, the residues of parental early experience, reactivated with their impending child (often encapsulated in the choice of a child's name; clinically, asking patients how they come to have the name they do often opens a window into this ancestral theme).

Winnicott contrasts the "environment mother" with the "object mother" from whom the child receives satisfaction of needs. This holding and mirroring function helps make sense of the infant's "spontaneous gesture" and – seeing himself being seen – to the emergence of a "true self", and a somato-psychic sense of personhood. Thus, a thirsty 1-year-old points at their cup; mother says "Yes, that's your cup; would you like a drink?"; this mirroring and underlining response gives meaning to the gesture, emphasising the child as an active agent engaged in constructing his own unique, yet shared, world.

For Wright (1991) and subsequent researchers (Fonagy, Gergely, & Target, 2007), the responsiveness of the mother's *face* as a mirror and later a symbol of relatedness is no less important than the much-vaunted "breast". Winnicott (1965) and Kohut (1977) throw this interactive, two-person light on Freud's "primary narcissism". For Kohut, "healthy narcissism" arises out of the "empathic mirroring" of the nurturing parent (or analyst), leading to an internalised nurturing *self-object*, not outgrown as object love supervenes, but remaining active throughout the life cycle. Good self-esteem emerges from the mutual absorption and devotion of mother and child. For Kohut, narcissistic disorders – with their defences of role reversal, compliance, and "false self" – arise, but on disruptions/deficits in this first all-important bond. This contrasts with the Klein–Kernberg model in which

such difficulties arise from internal threats to primary narcissism posed by unmodulated aggressive drives.

Winnicott retains the concept of omnipotent narcissism, but couches it in interactional terms by imagining a *transitional space* between mother and infant (transitional in the sense that it is neither self nor other, subjective or objective, inner or outer) in which the infant's wish is sensitively responded to by the mother. "His [the child's] wish is her command": by being there as though by magic, she intuitively fosters the illusion that the child has "created" the object. Feelings of self-efficacy and creativity in later life are built on these early beginnings. Observational studies of actual (as opposed to psychoanalytically reconstructed) infants have lent empirical support to these psychoanalytic hypotheses (Beebe & Lachmann, 2014; Gergely & Watson, 1996).

The interpersonal authors make a sharper distinction than in Kleinian thinking between normal and abnormal development. For Klein, there is always a two-way movement back and forth between splitting and integration, from the terrors and precarious security of the paranoid–schizoid position to the sadness but sanity of the depressive position. The interpersonal authors tend to see these primitive defences not as universal responses to the inevitable unmanageable anxieties of infancy soothed and integrated by adequate parenting, but as pathological manifestations of the infant's struggle to adapt in the face of inept or cumulatively traumatic parenting.

With normally responsive parents, a child can deal with "bad" experiences – a delayed feed, a cold cot, a respiratory infection, a boring day – by healthy protest, which will be accepted and "transmuted" by the responsive "breast". The parent can cope with this "normal" hate, with the infant who says, in effect, "Hello object! I destroyed you" (Winnicott, 1969), while the infant can keep an image of the good parent alive long enough for inevitable brief separations to be tolerated without feelings of persecution or abandonment. Everyday aggression and protest are linked to maternal "metabolising" and the capacity to survive loss. Indeed, a degree of frustration acts as a spur to exploratory self-confidence and resilience – "good enough-ness" trumps the "perfect parent". Eventually, "optimal disillusionment" (Kohut, 1977) leads to the acceptance of the reality of imperfection, which can coexist with a sense of persisting "ordinary specialness".

For Fairbairn (1952b), the fundamental trauma is maternal indifference: not to be intimately known, often associated with maternal depression, a perspective similar to that of the French psychoanalyst André Green's concept of the "dead mother" as formulated by Kohon (1999). The primitive defences (see Chapter 4) of disturbed adult patients – splitting, projection and projective identification, omnipotent control, narcissistic self-absorption – are not in this interpersonal model regressions or developmental arrests at "fixation points", but examples of "secondary narcissism", defences, or necessary withdrawal into

the self in the face of a hostile environment, perspectives discussed by both Symington (1993) and later Holmes (2015). Kohut (1971) calls these "breakdown products", resulting from failed nurturing.

Example: The "Oxo mother"

Mark was a young man in his early twenties suffering from schizophrenia. He heard voices telling him how bad he was, and saw visions of terrifying snakes and other monsters. He tended to be attracted to older, motherly women, who at first liked and took pity on him, especially as he was so "good" and biddable, but then found his possessiveness claustrophobic and rejected him. A similar pattern characterised his relationship with his analyst. His parents had been "hippies", both heavy drug users, who had found it hard to care for Mark, who had throughout his childhood oscillated between being fostered and living with his mother. His earliest memory was of "stealing" an Oxo cube (i.e. a package of dried beef extract) from the kitchen cupboard and gnawing it, while he heard his mother and her friends giggling helplessly in the next door room in a drugged state. Mark desperately sought nurturance from this "square" breast in the face of drastic environmental failure.

Although the different models start from opposing premises – for Klein "goodness" comes from without and "badness" from within, while for the interpersonalists the innocent child is corrupted by a deficient environment – in practice the two positions are not so far removed. Kleinians envisage good parenting as mitigating inherent splitting tendencies within the infant, while the interpersonalists and the self-psychologists emphasise the effects of bad parenting in calling forth splitting and other "primitive" defences. Since the real world is a mixture of good and bad, and infants from their earliest beginnings are able to love and hate, both accounts contain valuable insights.

Separation-individuation

Thus far, we have considered infants and their caregivers as isolated dyads. But it takes two to make a baby. In the Lacanian reading (Fink, 1997, 2011), even before the father becomes important, a third term has already arisen between infant and mother: *absence.* Klein, too, saw in this the germ of oedipality, as the absent mother is imagined to be with the father. Around 7 months of age the child begins to show stranger anxiety and to be much more aware of the mother's comings and goings. This was conceived by Mahler et al. (1975) as the beginnings of "separation-individuation", as the

infant begins to establish internal "object constancy", that is, the capacity to retain a mental image or memory trace of the absent mother – and, equally, of the absent analyst during weekends and breaks.

Attachment theory (Bowlby, 1988; Holmes, 2013) emphasises the way that separations are handled as the key to secure bonding; the parents provide a "secure base", both in reality and in the child's mind, from which he can begin to explore the world, and to which the child immediately returns when danger threatens. Mahler et al. (1975) identify a "rapprochement subphase" of separation-individuation in which, punctuating toddlers' ecstatic exploration, or "love affair with the world", they feel the need momentarily to return to mother for reassurance, perhaps fearing punishment for Einstein's "holy curiosity" (Hamilton, 1982), or transgressing oedipal prohibition.

Kernberg (1984) sees a maturational movement from paranoid–schizoid splitting to adaptive repression as the main defence against unwanted feelings arising around this time. In normal development, there is now a much stronger ego, based on internalisation and identification with a stable nurturant parent. The early superego is also beginning to emerge. The child is thus able to cope with some degree of integration of good and bad, rather than having to project them outwards.

As separation-individuation proceeds, the child begins to conceive of a world of autonomous individuals, each with their own vantage point: as he gathers a sense of his own emergent subjective self, so he begins to be aware that others have selves too. This is the cognitive aspect of the "depressive position", in which "good" and "bad" part-objects coalesce into a whole separate being, a source both of nurturance and frustration. Fonagy et al. (2007) depict this as the emergence of the child's "theory of mind" or mentalising capacity. This concept is especially important in the treatment of abused patients who may have defensively obliterated the horrifying idea that "caregiving" adults might have minds that could wish to harm or even destroy them. In treatment, they can begin to gradually recognise the analyst's mind and the analytic setting as safe and separate places that they can co-inhabit.

The Oedipal or three-person phase

Freud's conception of the Oedipus complex, first mentioned in a letter to his friend Fliess in 1895 arising out of his self-analysis following the death of his father, has become part of popular folklore (Freud, 1895a). In Freud's scenario, he imagined the little boy, like Oedipus, wishing to kill his father and usurp his place in his mother's bed. This wish to possess her arouses fear of retaliatory castration by his all-powerful father – the ultimate punishment of the loss of his genitals is symbolically enacted in the ritual of circumcision. The reality of castration is then confirmed by the little boy's sexual curiosity when he discovers that females lack a phallus, and in his mind must

therefore have been castrated – a view that is confirmed by the flow of menstrual blood.

Freud seemed to assume that the psychosexual world looked roughly similar to little girls, who therefore love their fathers and wish to replace their mothers and, lacking the essential organ of power and significance, also feel "castrated" and powerless. Freud saw the Oedipus complex as a necessary developmental task, ultimately "resolved" by *identification*. In the boy's case, this is by identification with the feared father, which offers him the promise of true potency in the future, and in the little girl's by identification with her mother, and by the promise that her lack of a phallus will eventually be compensated by the capacity to attract, and so "have", a man (since she cannot "be" one) and to produce something much bigger and better than a penis – a baby.

Contemporary psychoanalysis has been strongly influenced by the feminist response to this phallocentric account (Benjamin, 1990, 1995; Holmes, 2019; Irigaray, 1984; Kristeva, 2014; Zakin, 2011). Nevertheless, the Oedipus complex continues to resonate psychoanalytically in its account of a parental couple that the child both envies and feels cast out from, and in the experience of desire, prohibition, ambivalence, and identification that humans must negotiate on the pathway from infancy to adulthood.

We shall look in detail at four aspects of the Oedipus complex – the Kleinian and Lacanian perspectives, feminist responses, and the effects of social change. But first, we will consider the continuing relevance of Freud's original conceptions. As Mitchell (1988) points out, a central project of Freud's was to understand the psychology of male impotence ("where they love they do not desire, and where they desire they cannot love"; Freud, 1916, pp. 182–183). This issue was the starting point for the following case.

Example: His father's son, or his own man?

While not physically "impotent", Peter's presenting problem was his persisting inability to form stable relationships with women. A businessman in his early thirties, he had had numerous liaisons; in the early stages all went well, but whenever the possibility of commitment threatened, he would begin to panic and eventually, in his words, the relationship would "Peter out". A subsidiary problem was his moodiness and irritability at work, which, he said gave him a reputation for being "an awkward bugger".

Peter was the eldest of three boys with a very powerful and domineering father who ran the family business in which Peter worked, and with, a retiring and compliant mother. It soon became clear that Peter had modelled himself on his father, whom he both revered and feared, but that somehow the identity did not quite fit.

Secretly, he felt that he was "like" his mother – with whom he could talk and who expected him to come to regular meals with the family even though in theory he was living independently, and with which he complied so as not to offend her.

As yet another promising relationship foundered, Peter suddenly saw that the point at which things tended to go wrong was when he introduced girlfriends to his parents, and that seeing his father being charming to them filled him with feelings of inadequacy and envy, which he then projected on to the girlfriends, whom he saw as faithless and cheap. Expressing these thoughts in analysis created enormous difficulties for him, since he maintained a rather brusque and "tough" manner, and tended to dismiss the male analyst's comments with remarks like "You could be right" or "I hadn't thought of that", implying that these were crazy psychobabble comments, hardly relevant to a down-to-earth businessman like himself.

When his rivalry with the analyst was interpreted, he began to recall childhood feelings of misery and utter betrayal around the time his mother was pregnant with his brother, and episodes in which he was humiliated by his father, who tried to force him out of his taciturn sulks at mealtimes. He began to realise how stuck he was in a battle with his father, which he felt he could never win, and a secret intimacy with his mother, which no girlfriend could ever match, and even that his bachelorhood (which worried his mother dreadfully) was a reproach to her for her "faithlessness" in producing two more boys when, surely, he was good enough. When talking about this, he began to cry, and fully expected the analyst to ridicule or attack him rather than offer sympathetic understanding. After this session, he began to be much more assertive with his father, found a new girlfriend who lived abroad, and, by protesting his need for holidays to visit her that did not conform with analytic breaks, became less overtly compliant with analysis.

From an interpersonal perspective, this case illustrates the importance of parental handling and containment of the child's oedipal feelings. A mother needs to be able to enjoy her son's infatuation while at the same time not being seductive; the father must be able to accept this rivalry without feeling threatened by it, and be prepared to offer himself as a model, while accepting his son's wish to attack and belittle him. The case might also be seen as representing the father's failure to provide Peter with a valid initiation into manhood, which would have helped him to overcome his fear of being merged with his mother and, by extension, with his girlfriends. Peter's "castration anxiety" embodied this fear, as did his sense of psychic

mutilation. "A boy needs his father both to protect him from the danger that his mother represents for him, and to protect her from the danger he represents for her" (Horrocks, 1994). Equally, a father needs to be able to celebrate and admire his daughter's beauty and nascent sexuality without seduction or transgression, while the mother passes the baton of womanhood on to her daughter without feeling threatened or displaced.

The Kleinian perspective on Oedipus

For Klein, the seeds of the Oedipus complex are to be found in the earliest stages of infancy (Britton, 1989, 2018). Separation from the mother implies the existence of the father, and the child's own aggressive phantasies, which are aroused by the separation, are then projected into the father. This explains the ubiquitous phantasy of the punitive and prohibitive father of the Oedipus complex, who seems far removed from the reality of contemporary paternal attitudes. For Klein, negotiating the oedipal stage is linked with the maturation associated with progression from the paranoid–schizoid to the depressive position. In the latter, good and bad are kept separate until the child is able to accept the guilt and sadness associated with realising that they are embodied in one and the same person. Similarly, the resolution of the Oedipus complex requires children to accept their temporary exclusion from the parental couple, to allow mother and father to come together, and to tolerate the phantasy of "good intercourse" or "primal scene".

In this contemporary version of the oedipal scenario, the child "loses" the mother, but in compensation makes essential psychic gains. First, the child acquires the capacity to think – in that creative thought is "procreative" – bringing together disparate ideas in new combinations. Second, Oedipus is a spur leading to autonomy. The child begins to lead his own inner life, no less inviolable than that of the parents' mutual desire. Third, the father begins to play a role in the child's life as a gendered and distinct being, and not just as an alternative mother.

The Lacanian perspective

Lacan (1977), discussed by Bowie (1991) and Fink (2011), reformulates Freud's ideas in linguistic terms as *metaphors* rather than scientific facts. Couched in terms of linguistics and anthropology, they constitute a devastating account of the psychological structures of a patriarchal society. To describe is not necessarily to condone.

For Lacan, himself a product as much of francophone Catholicism as of Judaic psychoanalysis, a crisis in development arises around the age of 2 years when the child begins to acquire self-awareness and language. In the anthropology of Eurocentric cultures, the primitive pre-oedipal unity of mother and child is shattered by the advent of the "no(m) du père". This is

simultaneously the "name of the father" (as opposed to the maternally transmitted "Christian" name), and also the "no[n]" – the prohibition, placed like the archangel's sword at the gates of paradise by the mother's jealous husband. Language (a "mother-tongue", but policed by patriarchy), as a cultural given, begins to determine the child's experience of the world. Sensory impressions coalesce into objects, named and classified by the power of society, the most potent symbol of which is the phallus. Contra-Freud, it is not so much that females lack power because they have no penis; rather, because they lack power, they are subject to the law of the phallus (Birksted-Breen, 1996). Note too that recent anatomical research has brought the clitoris into view as a complex and extensive physical manifestation of female desire and (in its wider sense) potency (Zachary, 2018).

For Lacan (1977), just as a child's oedipal experience is shaped and potentially alienated by language, so the objectification of the "mirror-stage" means that his self-perception estranges him from his primeval unreflective self. If a coloured dot is crayoned on a child's forehead and he is shown himself in the mirror, he will, up to the age of about 2 years, try to touch the dot in the mirror; after 2 years, the child will touch his own forehead, suggesting that self-awareness arises at around that age (Tomasello, 2019). This "mirror stage" can be understood in oedipal terms of the "I" (eye) seeing "me", an objectification of the self that depends on the "third term" (i.e., the father and, with him, language), a new vantage point outside the mother–infant couple, creating a triangle with the possibilities of feelings of exclusion and envy (i.e., alienation), but also freedom of movement and abstract thought.

Ironically, this Lacanian model could itself be seen as patriarchal, in that, in a patriarchal and dominant way, it excludes two vital non-oedipal aspects of language. First, the fact that every thought and conversation, whether "internal" or real-life, is unique, new-minted, and original. Second, it misses the poetics of language – its ambiguity, tone, timbre, and music, none of which are subject to the phallocentric rule, and reflect instead the "horizontal" (as opposed to oedipally "vertical") materno-centric aspects of communication.

Feminism and Oedipus

Feminists seized on Freud's views on female sexuality as expressed in the Oedipus complex as the ultimate example of patriarchy and male chauvinism (Irigaray, 1984; Kristeva, 2014; Quindeau, 2013). But here again, we encounter a paradox. One of the strengths of psychoanalysis is its emphasis on bodily experience and the biological fundamentals of feeding, elimination, sexuality, physical illness, and death – "the ego is first and foremost a bodily ego" (Freud, 1923, p. 16). On the other hand, if taken literally, Freud's idea of females as castrated males, who are to achieve fulfilment only through

producing a "penis-baby", is absurd, biologically ignorant, and insulting. The early female analysts – Klein, Horney, and Brunswick – responded to Freud's patriarchal bias not so much by challenging him directly but by moving away from the role of the father to a focus on the early mother–child relationship. In their versions of psychopathology, in place of "penis envy" in women (and "Peter Pan" boys who never grow up) these authors depicted the spectre of an all-powerful, all-giving maternal breast, to which males respond by denigration and distancing, and into which females get sucked and sometimes depressively stuck. For Chasseguet-Smirgel (1985), the essence of the oedipal stage is the discovery and working through of the "double difference" – the difference between the sexes and the difference between the generations. She saw "perversity" – at an individual and a social level – as based on a denial of this difference, the oedipal boy building his factitious potency out of a "faecal penis" composed of hatred and fear. Similarly "penis envy", so called, arises out of a woman's devaluation of the power and generativity of her own body, deriving from a failure of identification with her mother.

The next generation of psychoanalytic feminists includes Chodorow (1978, 1989), Sayers (1992), Mitchell (1999), and Benjamin (1990, 2004). Benjamin, a relationalist, emphasises Freud's notion (borrowed from Fleiss) of the inherent bisexuality of the human psyche. Benjamin visualises an early oedipal stage before gender identity is fixed, at which activity and receptiveness, exploration and passivity, inner space and outer space, assertion and submission are available to both sexes and emerge as much in boys' as girls' play. She sees the role of the father not just as representing prohibition and power, but as a vital resource, offering excitement for the child and recuperative space for (and from) the mother, a suggestion that has empirical support (Cowan & Cowan, 2019). Like Temperley (1993), Benjamin is critical of the overemphasis in the Freudian–Lacanian account of power and domination, stressing instead the need to recognise and value playfulness, creativity, and conflict-free "inner space".

The reality of the modern family

In a contemporary "Western" context, Benjamin highlights the vicissitudes of the real relationship with an actual father and the distortions that might occur in single-parent families. "Masculinity" becomes idealised and invested with dominance and unwarranted power, or is projected into a "phallic mother", who is unattainably desirable and terrifying, creating what Lasch (1979) has called a "culture of narcissism" in which the individual has to rely on self-investment as a means of survival in a world in which caregivers are absent, distracted, or irredeemably unreliable.

Despite Freud's ahead-of-his-time tolerance towards homosexuality, psychoanalysis has been powerfully criticised for its heteronormative viewpoint (Giffney & Watson, 2017). The de-pathologizing of same-sex relationships

and reluctant acceptance of diverse child-rearing practices has been a painful process within mainstream psychoanalysis. It remains an area of active controversy and research.

The ethnocentricity of Freud's Oedipus myth has also been challenged (Gu, 2006), although Barratt (2019) argues that despite cultural variations, incest remains an anthropologically universal rule. Several authors (Holmes, 2019; Young, 1994) point out that Oedipus was himself an abused child, left to die by his father Laius, because he feared the oracle's prediction that he would be killed by his own son. This perspective on the myth opens out an interpersonal, intergenerational viewpoint that fits with the realities of the modern family. The sexually abusive father, or, more often, step-father, with a mother who fails to protect or turns a blind eye to what she unconsciously "half-knows" is going on, represents for the little girl the nightmare version of the oedipal myth in its modern form. Both abused and abuser are trying to escape from this cold oedipal world of neglectful separation to a pre-oedipal state of fusion and obliteration of difference. What makes trauma "traumatic" is the piercing of the normal barrier between phantasy and reality (Garland, 2002). That which the child so desperately wants in phantasy becomes painfully overwhelming in reality. The regressive transferences seen in patients who have been abused reflect both the search for a secure and responsive mother who will protect, and the need for a father who can allow closeness while still respecting his daughter's inviolable privacy.

Example: Oedipal themes in the transference of an abused patient

Ella, a 50-year-old divorced teacher with a grown-up daughter, suffered from depression and some traits of borderline personality disorder. She had been systematically humiliated as well as physically and sexually abused by her father throughout her early childhood, until her parents' separation when she was 11. Her mother was herself intimidated, exhausted, and neglectful. Ella's earliest memory was of being hurled across the room at the age of 3 years when she had asked her soldier father, just back from warfare, to play with her.

She was hypervigilant, sensitive to the slightest lapse of concentration from the analyst. Her sessions were the antithesis of Winnicott's (1971) notion of being "alone in the presence of the (m)other"; she found it almost impossible to relax enough in analysis to explore her own inner world, constantly trying to second-guess what her analyst would think of her or want her to be saying. Just as her father had abused his paternal role by his invasiveness while her mother was

unavailable, so the analyst's countertransference swung between feeling detached and sleepy, and feeling uncomfortably intruded on.

On one occasion just before a break, Ella brought a set of pocket chess into the session, inviting the analyst to play with her. He was torn between the wish not to make her feel rejected, while resisting and suspecting this invitation to a mutual "acting in" (see Chapter 9). After a while, when Ella evidently had felt humiliated by his refusal, he interpreted this along the lines of her simultaneous longing for and terror of intimacy, heightened by the impending break. He suggested that he saw the wish to play as a positive reaching out, but that the idea of a rule-bound board game (which one of them would "win") was a reflection of her despair at being unable to play spontaneously and non-competitively with her thoughts and those of the analyst.

Implicit in this interpretation was the idea that the "good" oedipal parent, for Ella so conspicuous by its absence, is not so much a chess adversary, but is just "there" (Balint, 1993), neither present nor absent, not too close nor too far away, a "transformational object" (Bollas, 2009; Ogden, 2008) grounded in reality but able to be incorporated into phantasy.

Summary

Oedipality is a continuation of the two-person phase, which precedes it. The main issues of the pre-oedipal period are as follows:

1. The forming of affectional bonds with a nurturing parent and the achievement of a secure base from which exploration of the inner and outer world can occur.
2. Learning to tolerate separation and absence and to respond with healthy protest, rather than split-off hatred and envy.
3. Learning to think and to feel via the sensitivity of the nurturing environment, which turns preconceptions into conceptions and modulates affect so that it becomes manageable.
4. The emergence of a stable sense of self and others, able to survive separation and angry attacks.

In the oedipal phase, the core themes of intimacy and separation, and of similarity and difference, are projected on to the three-dimensional screen of two parents and the child. Children learn how to be close enough to their parents so as to feel special and loveable, but not so close as to be engulfed; how to respect limits and boundaries without feeling unbearably excluded; how to tolerate envy without being overwhelmed by it or using it to destroy.

Compared with its emphasis on the early years of life, psychoanalysis has tended to have less to say about the later phases of the life cycle, and space allows us to touch only lightly on these important topics. However, neuroplasticity ensures that developmental pathways are never fixed (Belsky & Pluess, 2009). Later good experiences (including psychoanalytic treatment) can compensate for earlier environmental failure, leading people away from the vicious circles of neurosis towards the benign cycles of psychic health.

Adolescence

After the dramas of the oedipal phase, and before their continuation in adolescence, there follows a period of comparative quiet. This "latency" provides respite, a period in which psychosexual development and emotional maturation continue in a more muted vein, and in which the acquisition of cognitive and motor skills, and the capacity to go beyond the family into a world of peer relationships, are the predominant developmental tasks.

Just as the ways in which love, sensitivity, and separation have played out in the two-person phase shape the succeeding oedipal stage, so too a child's oedipal experiences will equip him for good or ill during the turbulence of adolescence. Each developmental step is both a continuation of the past and an opportunity for new beginnings.

Adolescents face the twin tasks of separation from their family of origin and preparing themselves for the intimacies of their potential family of generation. Central themes include the body (Laufer, 1989; Laufer & Laufer, 1984), identity (Erikson, 1968), and the role of friendship and peer relationships. Adolescents no longer rely on their parents to regulate and modulate their bodily affective states, but begin to undertake this task for themselves – those with anorexia nervosa who do not know when they are hungry, or when they have had "enough", struggle with this task (Wooldridge, 2018). An upsurge of sex hormones and neuronal pruning ensure that adolescents engage in a continuing process of recalibrating gender identity and desire (Blakemore, Burnett, & Dahl, 2010). The search for a sexual partner who will mirror, confirm, and validate one's unique needs and place in the world begins (Target, 2007).

Adolescents have to learn how to entrust others with their disappointments and anger as well as their sexual desires, and not to feel that they will be destructive or rejected (Waddell, 2018). The complexity of the intense social environment of the human species means that learning to understand oneself is a vital part of knowing how to understand others and one's relationships with them. Making choices and beginning to create a world of one's own carves out the beginnings of a stable identity. Parents' primary influence is supplemented or replaced by peer-generated ideas, systems, role models, fashions, and aspirations. These contain and define the self whose lineaments are beginning to solidify. A negative identity built around protest

and a preoccupation with what one is *not*, or a conformism based on compliance with parental aspirations, may equally conceal inner feelings of emptiness and loveless disconnection. Psychoanalysis with adolescents (see Chapter 9) is difficult, since it represents their worst fears of being odd or abnormal, but when engaged in can provide a vital "moratorium" or "spielraum" (Erikson, 1968) within which adaptive regression can occur.

Example: Oedipal inhibitions

David was a pleasant 17-year-old presenting with panic attacks that had temporarily overwhelmed him, making him unable to leave the house alone or study effectively. His movements were tentative, as though he did not quite inhabit his adult body, his hair and voice slightly soft and childlike. A middle child, he had a successful elder brother and a much adored younger sister. The family was supportive, but tense. David's father, a builder, had severe asthma, which had left him unable to work for long periods. The family was in financial difficulties and there was pressure on David to leave school and earn his living. David was very close to his mother, sympathising with her worries about his father's health, but he resented her pushing and domineering manner, and he envied her more straightforward relationship with his sister, feelings he expressed by sulky withdrawal.

During his sessions, David was polite but wary, communicating a sense of helplessness and a passive wish that the analyst should instruct him how to live without fears. He felt guilty about following his own interests rather than helping in the home, where he felt he was needed. At times, he felt his life was empty and meaningless. He had a girlfriend, of whom his parents did not entirely approve, with whom he shared a bed but did not make love. Interpretations focused on the connection between his presenting anxiety and the oedipal fears of breaking the bond with his mother if he made a sexual relationship with his girlfriend, and of triumphing over his damaged father if he was successful in his exams and achieved sexual potency, linking this with his cautious and deferential attitude towards the analyst. David was at first outraged at this "ridiculous" suggestion, insisting that he and his father were the best of friends, but he then admitted that he did resent the way he felt that his father favoured his elder brother. This open conflict with the analyst seemed to shift things. By the end of David's time-limited treatment, he was feeling better and had been to two school dances, made love enjoyably with his girlfriend, and his exams had gone reasonably well.

Adulthood

Psychological development does not come to an end once physical growth is complete. It takes a lifetime to learn to love and work. The vicissitudes of attachment, separation, and loss continue throughout the life cycle. Erikson (1968) schematically saw the task of young adulthood in terms of *relatedness versus self-absorption*; of the middle years as *generativity versus stagnation*; and of old age as *integrity versus despair*.

A somewhat arbitrary, and no doubt culturally biased, list of the developmental challenges of adult life include the following:

- The acquisition of skills, both practical and interpersonal.
- The capacity to submit to tutelage but to challenge it when necessary.
- The capacity to love a partner, "in sickness and in health".
- Tolerance of the transition from romantic to conjugal love in long-term relationships.
- To love and to hate without fear.
- To hold the balance between immersion and detachment as a parent.
- Achieving stability and security while still being able to explore new territory.
- Coming to terms with loss, and learning to grieve appropriately.
- Acceptance of the inevitability of one's limitations and eventual death (Jacques, 1965).
- Acceptance of loneliness (Nemiroff & Colarusso, 1990).
- Being able to detach oneself from one's children, one's occupation at retirement, and, in the end, from life itself (Valenstein, 2000).
- Retaining appropriate optimism and not being overwhelmed by despair.

Psychoanalysis sees the way we respond to the slings and arrows of outrageous fortune as being shaped by mental structures that derive from childhood. We bring the history of our early relationships to each of the above "tasks". Becoming a parent reawakens oedipal phantasies; through our children we look back on our own childhood. In the "midlife crisis" (Jacques, 1965), awareness of the reality of death triggers a re-working of the paranoid–schizoid/depressive interface as we move towards acceptance or violent repudiation of our limitations and finitude, or oscillate between the two.

A psychoanalytic perspective emphasises the interplay between three basic polarities of the continuing developmental process: (a) connection and separation, (b) destruction and reparation, and (c) self-love and other-love, all of which have their origins in childhood but are also played out on the broader canvas of adulthood. Here, we shall touch briefly on three topics: mourning, marriage, and maturation.

Mourning

The idea that suppressed mourning leads to psychological difficulties and, conversely, that facing loss and expressing grief are curative, is central to much psychoanalytic work . Following Abraham's suggestion, Freud (1917; Carhart-Harris, Mayberg, Malizia, & Nutt, 2008) drew attention to the parallels between depression and normal grief. He saw that in depression the sufferer is struggling not just with himself but, often unaware, with a *relationship*, as "the shadow of the object falls on the ego" (Freud, 1917, p. 158). Freud was himself struggling with the horrors of the First World War (Schimmel, 2018).

The work of mourning involves the paradox that in acknowledging what is lost, the bereaved person is at the same time reclaiming it. Based on her own mourning for her son, who died in a climbing accident, Klein (1940) realised that what was at stake in loss was the integrity of the whole inner world. She therefore linked loss with internalisation, and her vitally important concept of "reinstatement of the lost object":

> through the work of mourning [the bereaved person] is *reinstating* all his loved internal objects which he feels he has lost ... Every advance in the process of mourning results in a deepening of the individual's relation to his inner objects, in the happiness of regaining them when they were felt to be lost. (Klein, 1940, p. 362) (our italics)

Many of the tasks and transitions of adult life involve the balance between gain and loss. In the depths of bereavement, all and everything feels lost. For Klein, there are key connections between the childhood handling of loss – of the breast, the exclusive relationship with the mother in the oedipal phase, parents as one goes to school, and so forth – and adult responses to separation. Where loss can be mourned (including healthy protest) then the lost object is ultimately available to be "reinstated" internally. This leads to an enrichment and deepening of the inner world, which can balance the sadness about what has gone with the freedom and opportunities new stages of life might afford; where this process goes awry, depletion and depression may follow. Much of the work of analysis centres around the regaining and reinstatement of lost objects. The analysis itself becomes an "object" that, between sessions and during breaks, is constantly lost and found, so that finally, at termination, the patient will have internalised the loss–recovery–reparation–reinstatement cycle even though the relationship with the therapist has come to an end.

Marriage and adult couple relationships

Given that a high proportion of people seeking psychoanalysis are suffering as a result of either the problems of "relationships", or the lack of them, the

psychoanalytic literature specifically devoted to marriage (defined here as long-term emotional and sexual coupledom, whether or not legally formalised) is surprisingly scant, with some notable exceptions (Balfour, Morgan, Clulow, & Thompson, 2018; Clulow, 2009, 2001; Dicks, 1967; Ruszczynski, 1993). This flows perhaps from psychoanalysis's primary focus on the inner world of individuals and its origins in the early years rather than current relational contexts. Psychoanalytic couple therapy, drawing on systemic thinking as well as psychoanalysis, is, however, a discipline in its own right (Abse, 2019; Scharff & Scharff, 2014). Falling in love, and the search for the sexual, emotional, intellectual, and moral intimacy of marriage, requires a retracing of the history of the inner world and its mutual alignment with the partner. This inner process parallels the way in which lovers exchange their "external" life stories and incorporate one another into their respective families.

Marriage is therefore the most potent and fertile source of "transference" outside of the psychoanalytic relationship. A partner is a potential "transformational object" (Bollas, 1987), a vehicle for projection, a receptacle for unwanted aspects of the self, a source of delight and terror, bringing one in touch with one's deepest desires and disappointments. This potential for transformation or destructive repetition (most marriages contain elements of both) suggest that health is not an escape from transference, but integral to it. Transference is, in Slavin and Kriegman's (1992) terms, a "retranscribing of the relational environment", a "probe" based on past affective experience embodied in "semantic memory", which, when marriage (or therapy) goes well, leads to the mutual emergence of new patterns of maturity. From this perspective, marriage contains an implicit therapeutic hope that deep phantasies and conflicts will be transcended and reworked, rather than merely repeated.

Maturation

Implicit in the developmental perspectives of psychoanalysis is the idea of maturation. But what does it mean to be "mature"? And is "immaturity" always problematic? For Freud, maturity – and, with it, psychological health – meant becoming more reality-oriented, as expressed in his Zuider Zee metaphor of the reclamation of the unconscious by the conscious (Freud, 1933), his view of neurosis as a "turning away from reality" (Freud, 1924, p. 202), and his famous aphorism "where id was there ego shall be" (Freud, 1923, p. 80). Implicit in Freud's work is also the notion of the coherence of an inner world illuminated by self-knowledge, and the acceptance of and mutual communication between different aspects of oneself. Unlike Freud, who tended to discount the chances of major psychological change after the age of 40, Jung (1916) was very interested in the second half of life, and especially in the process of "individuation" in which one gradually

becomes one's unique self. As the unconsciously Jungian country singer Dolly Parton said in her prescription for success: "Find out who you are, and then do it on purpose".

Mahler et al. (1975) yoke Jungian and Freudian perspectives together in their concept of "separation-individuation". Some psychoanalytic writers emphasise the outgrowing of childish preoccupations, stressing hard-won heroic autonomy as the goal of treatment and as an ideal state of emotional health. This viewpoint has been criticised by authors such as Bowlby (1969) and Fairbairn (1952a), who see dependency as integral to the human condition and autonomy as the false goal of a consumerist society intent on producing "normosis" (Bollas, 1987). Fairbairn (1952a) described maturation as a movement from immature to mature dependence, and Kohut (1977) insisted on the need for the persistence of "self-objects" – that is, "narcissistic" and "special" relationships with spouse, children, and parents as well as ideas, places, pets, mementos, and so forth – throughout life. These authors see development as a dynamic system, an equilibrium balancing past and present, and maturational and regressive tendencies. Klein (1957), too, postulates a shifting balance between paranoid and depressive positions continuing throughout life. This non-idealised perspective explains the way in which an overwhelming trauma can bring out "primitive" responses in the most mature of individuals (Garland, 2002), and how psychoanalysis, like life itself, is always an "unfinished journey".

Conclusion

Psychoanalysis as a developmental discipline provides models for understanding the affective interactional matrix between patient and therapist. Analysts constantly search for childhood-derived themes in the tribulations of adult patients and try to reconstruct from the transference and countertransference the pre-existing developmental situation in which the patient is ensnared. The search for this "inner child" is not just a metaphor. It connects the hermeneutic project of psychoanalysis – the construction of meaning through a life narrative – with the empirical world of developmental science (Bruner, 1990; Fonagy & Target, 2007; Holmes & Slade, 2018). The mind has a developmental history no less than the body. Reconstructing, redressing, learning from, and building on the positive aspects of this history are tasks central to the work of psychoanalysis.

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Chapter 4

Mechanisms of defence

> The ego makes use of various procedures for fulfilling its task, which, to put it in general terms, is to avoid danger, anxiety and unpleasure. We call these procedures "mechanisms of defence". (Freud, 1937, p. 235)

We saw in Chapter 2 how models of the mind can be divided into those that are predominantly intrapsychic, interpersonal, or mixed. Similarly, the concept of defence, and even the individual defence mechanisms themselves, may be viewed from an intrapsychic, interpersonal/relational, or mixed point of view. Some defences refer primarily to internal life (e.g., repression), others to interactional or interpersonal phenomena (e.g., projective identification and splitting), and yet others to both, such as denial.

The concept of defence

Classical psychoanalysis views defences primarily from an intrapsychic perspective, placing conflict between wishes and external reality, and between the different agencies of the mind, at the heart of psychic life. Adaptation to these tensions and opposing forces is made possible by *defences* – psychological configurations operating outside the realm of consciousness, which minimise conflict, reduce tension, maintain intrapsychic equilibrium, regulate self-esteem, and play a central role in dealing with anxiety, whether it arises from internal or external sources. More contemporary models, while being respectful to the classical view, emphasise the dynamic and interpersonal aspects of defence.

The use of the term "defence" is somewhat unfortunate, though. It implies that there is a threat from hostile forces, requiring a retreat, and suggests there is a barrier to be overcome. Clinicians can be forgiven for thinking they have to "breach" defences, that is, to make that which is repressed conscious, if more meaningful mental life is to be explored. Yet, defences are adaptive, organisers of self-experience and perception of others, and necessary for effective regulation of emotions, both pleasurable and

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unpleasurable. "Breaching" defences in clinical work may be harmful rather than helpful, so current psychoanalytic intervention is more nuanced about the imperative of "interpret the defence, release the anxiety, and expose the hidden meaning".

Recently, transdiagnostic as opposed to categorical conceptual approaches to mental disorder have gained prominence, positing that there are fundamental mental processes that are responsible for a range of disorders. Defence mechanisms fit well with this new approach. Defences transcend diagnostic categories and therefore provide a way of thinking clinically about underlying psychopathology, and are strong contenders as one of the fundamental mental processes to be mapped systematically as part of an initial clinical assessment.

For example, Kernberg, Yeomans, Clarkin, and Levy (2008) describe borderline personality disorder (BPD) as a condition in which there is excessive use of specific and developmentally early mental mechanisms – splitting, denial, projection, and projective identification – rather than defining the condition solely on descriptive characteristics described in DSM-5 (American Psychiatric Association, 2013). This allows BPD to be seen as a complex and variable condition, rather than as a singular homogeneous disorder, characterised by a range of functioning from mild to severe defined by the pattern and type of defences used. The more severely affected patients use primitive defences in a wide range of circumstances, for example, most social and personal interactions, while those who are less severely affected activate the same defences but in a more limited range of contexts, for example, only in intimate interactions. This detailed understanding of defence organisation permits an individual approach to treatment and is more in keeping with the current proposals of a dimensional approach to personality disorder suggested in the appendix of DSM-5 (American Psychiatric Association, 2013). Seen this way, the severe interpersonal dysfunction and emotional dysregulation of borderline psychopathology arises from the use of specific defence mechanisms triggered by uncontrolled anxiety.

Relational models in psychoanalysis emphasise defence mechanisms as a protective shield within which the authentic self is held: defences form part of the attempt to facilitate the development of a "true" (Winnicott, 1965) or "nuclear" (Kohut, 1977) self in the face of a defective relational environment. The focus is on the adaptation of the individual to environmental pressure. Alvarez (1992), in keeping with Freud, has taken this point further and considers some uses of defence as developmentally necessary. The boasting of the little boy becomes a powerful force in overcoming inferiority and attaining manhood; omnipotent and paranoid defences, rather than avoiding inherent destructiveness or innate division and conflict, represent attempts to overcome and recover from states of terror and despair resulting from environmental failure.

Bowlby (1969) reframed defences further in interpersonal terms, basing his view on attachment theory (Holmes & Slade, 2018). Secure attachment to a responsive and protective caregiver provides a positive primary defence. Secondary or pathological defences enable the child to retain a degree of closeness to rejecting or unreliable attachment figures. In "avoidant attachment", both neediness and aggression are split off in order not to alienate a rejecting caregiver. Here, the individual has little conscious knowledge of the need to be near the attachment figure, appearing aloof and distant. In "ambivalent attachment", lack of caregiver predictability fosters clinging and uncontrolled demandingness.

These formulations suggest that what we think of as "personality" is an interaction between self-representation and interpersonal relatedness, and how these in turn emerge from how defence mechanisms are deployed (to continue the quasi-military metaphor). Secure attachment involves a subtle balance between relatedness and self-definition – a balance that contributes to the development of mature levels of interpersonal relatedness. Here, defence mechanisms are adaptive in that they protect personal autonomy while acknowledging others' contribution to one's safety and self-esteem. This balance fosters an essentially positive sense of self and identity within affiliation and intimacy, and increases personal resilience.

From a psychoanalytic perspective, resilience implies that a potentially stressful interaction is mentally *represented* – as opposed to being denied or repressed – and that this representation is appraised using an array of psychological "mechanisms", including agency, attention, general intelligence, and self-awareness. Defences help to manage emotional responses to adverse experiences – the "slings and arrows of outrageous fortune". Knock-backs lead to bounce-backs and emotional survival. These processes tend to be compromised in those with insecure styles of attachment. The avoidant individual pushes difficult feelings away, with short-term benefit, but these unmetabolised affects can erupt into catastrophic misery or trigger somatic symptoms. In anxious attachment, setbacks exacerbate dependency and, if let down, major regression may result.

In sum, a number of key issues arise from this refining and repositioning of defences in mental life. First, they are adaptive and part of the system regulating anxiety and other emotions, and contribute to resilience, and need to be respected as such by clinicians. Psychological defences are just as necessary as the defences against infection and cancer provided by the immune system. Second, they are central to self-experience and the ways in which others are experienced and related to, and coalesce to form stable and recognisable personality characteristics. Third, they are organised hierarchically, so that excessive use of lower (primitive) levels is associated with more severe pathology, while their adaptive use increases personal resilience. Fourth, they vary across the lifespan, and those that are appropriate at one stage of life may be less so at another.

Coping mechanisms

Defences are often contrasted with coping mechanisms. In contrast to the unconscious nature of defence mechanisms, coping mechanisms are supposedly (a) conscious and (b) mobilised to deal with external rather than internal threat. This distinction, though, is complex (Kramer, 2010). A number of everyday coping activities occur automatically, much like a reflex, while a refusal to listen to something or a denial of particular feelings may be entirely conscious. Indeed, the perceived danger of an external threat requires internal assessment, which is itself dependent on unconscious antecedents, and so there can be no clear distinction between internal and external conflict, with the two interacting in a complex way. Nevertheless, defences tend to reorganise how reality is perceived, while coping mechanisms attempt to solve a problem and change reality.

Coping strategies can be taught and further developed into cognitive-behavioural strategies, which can be operationally defined for research purposes. Horowitz, Markham, and Stinson (1990) attempted to conceptualise mechanisms of defence within cognitive psychology; they saw defences as the outcome of cognitive control processes that sequence ideas and join meanings together. Thus, defence and coping mechanisms are related phenomena (Skinner, Edge, Altman, & Sherwood, 2003), being both adaptive and potential sources of pathology. Coping mechanisms are mobilised to reduce the effect of external stressors, while defences are activated if the results are ineffective in reducing internal mental distress.

History

Repression – a fundamental defence

Repression, the pushing back of unacceptable wishes and memories from consciousness, is the classical primary mechanism of defence, first described by Freud (1894, 1915), and seen by him as the "cornerstone on which the whole structure of psycho-analysis rests" (Freud, 1914, p. 16). Initially, Freud used the terms "repression" and "defence" almost interchangeably, seeing the processes as specific to the development of "hysteria" – that is, the translation of unacceptable affects into physical symptoms. However, he gradually differentiated them, using the term "defence" more generically, while "repression" gained specificity as a mechanism ensuring that wishes that are incompatible with reality or superego imperatives remain unconscious or disguised. The downside of excessive repression is that neurotic symptoms can occur when repressed affects emerge unbidden in the face of stress.

Repression accounts for forgetting – partial or total – of significant adverse experiences. The principle that the mind actively suppresses painful memories, and that memories change qualitatively over time, is generally

accepted. In general, these memory distortions occur in response to stress. A repression-related mechanism, *dissociation*, usually attributed to Freud's predecessor Janet, is currently much discussed. Both repression and dissociation describe what happens when overwhelming experience has to be managed mentally, but dissociation is seen as potentially reversible, whereas the contents of Freud's concept of primary repression are thought of as being beyond retrieval (see Barratt, 2013, 2016, 2019).

Repression and dissociation are often described in the context of exposure to childhood trauma. While episodic memory may not develop until around the age of 3–5 years, it is likely, via procedural memory, that younger children encode experiences much earlier, even though they may not be able to fully describe them later. Trauma interferes with encoding processes and disrupts the memory system, probably by damaging normal hippocampal development (Bremner, 2006). The sufferer may be left with fragments – images, smells, emotions – that cannot be integrated into a coherent narrative or a coherent sense of self. Psychic distress is thus avoided, but at a price. The inherent tendency of repressed wishes and impulses to return to consciousness – the "return of the repressed" – means that tension and anxiety remain, and further "secondary" defences – avoidance, projection, or compliance, for example – are then mobilised to alleviate the resulting inner conflict, reduce tension, and stabilise the personality. But all this occurs at the cost of distorting internal and external reality.

Anna Freud

The adaptive and interpersonal aspects of defence were elaborated by Anna Freud (1936). She contrasted *dynamic defences* with permanent or *character defence* phenomena such as those described by Wilhelm Reich (1925, 1933) as "Charakterpanzerung" (character-armour). Anna Freud elaborated the process of *identification with the aggressor* (discussed later in this chapter). This was first described by Ferenczi (1949) as an interpersonal and interactive defence mechanism, now seen as an important phenomenon in hostage negotiation, terrorism, and even social change, as groups of people identify with a strong figure in the context of helplessness.

Writing at the same time as Anna Freud and, like her, in the mainstream classical psychoanalytic tradition, Hartmann (1939), the founder of ego psychology, placed special emphasis on "conflict-free spheres" of the ego that were not solely associated with conflict, and this led to greater emphasis on normal aspects of the personality and the need for "healthy" defences.

Melanie Klein

Klein (1946) emphasised a new array of defences, including splitting of the object (a development of the term from Freud, who used the term "splitting" initially to

describe the division of consciousness as a result of conflict, and then later as a cleavage of the ego to manage a more damaging rupture), projective identification, omnipotent control over objects, idealisation, and devaluation (see Chapter 2), seeing them as primitive defences, that is, those that typify early stages of psychological development. Klein's followers have developed these ideas, and now see defences not so much as transient psychological processes brought into play when necessary, but as psychological configurations that, in psychological illness, coalesce to form a rigid and inflexible system. These personality-entrenched defence systems have been variously known as narcissistic organisations (Rosenfeld, 1964), defence organisations (O'Shaughnessy 1981), and pathological organisations (Steiner, 1982). They are conceptualised as manifestations of powerful, controlling internal objects (see Chapter 2). Metaphors abound: Meltzer (1968) described a "foxy part" of the self that continually persuaded narcissists of the attractions of grandiose and destructive aspects of relationships. Rosenfeld (1971) identified an internal "Mafia gang" that demanded emotional "protection money" from the good parts of the personality, which are then forced to collude with the "gang's" idealisation of destructiveness, and devaluation of love and truth. Sohn (1985) writes of the omnipotent self, created by identification with an external object, the weak and needy parts having been discarded, to form an arrogant "identificate", which then takes over the whole personality (see also Chapter 10).

This "structuralisation" of defence systems has also been applied to social systems and groups (Bion, 1961; Pines, 1985) driven by destructiveness or the equivalent of "foxy parts" and "Mafia gangs". These ideas form a major aspect of psychoanalytically informed intervention into organisations (Hinshelwood, 1986, 1994; Jacques, 1955; Menzies Lyth, 1988). Implicit throughout is the view that defences, however necessary for everyday psychological survival they may be, can also become maladaptive and lead to recognisable personal characteristics and symptom formation. This is especially likely if primitive methods of defence are reawakened through regression in the face of trauma, or remain active through ongoing developmental adversity (Freud, 1894, 1896, 1926).

The psychoanalytic model of defences, both necessary and self-defeating, is strongly supported by Vaillant and colleagues' studies of the life course of a group of men from late adolescence through to old age (Bond & Vaillant, 1986; Vaillant, 1977, 1992, 2015). This work has shown that there is a continuum of defences from normal or mature through to pathological, and that the use of more mature defences is correlated with successful life adjustments in work, relationships, and medical history. Unsurprisingly, mature defences, the capacity to mobilise constructive coping mechanisms, and personal resilience are linked.

The classification of defences as (a) psychotic/immature or primitive, (b) neurotic, and (c) mature links specific aspects of childhood psychological functioning to emotional difficulties in adulthood. However, it is important to note that the use of "primitive" mechanisms is not in itself pathological. As

mentioned, they can emerge in psychologically healthy individuals exposed to extreme stress (Garland, 2002); it is their persistent use that is maladaptive.

Summary

The main features of defences are that they are

- normal and adaptive as well as pathological, and vary over the lifespan;
- a function of the ego;
- usually unconscious;
- dynamic and ever-changing, but may coalesce into rigid, fixed systems in pathological states and in character formation; and
- when maladaptive, associated with different constellations of symptoms: for example, repression in hysteria; isolation and undoing in obsessional neurosis.

We shall now consider some of the individual defences in more detail, starting with the psychotic/immature or primitive mechanisms, and then moving on through some of the neurotic defences to those of maturity. A list of defences is given in Table 4.1.

Table 4.1 Mechanisms of defence

Primitive/immature	*Neurotic*	*Mature*
Autistic phantasy	Condensation	Humour
Devaluation	Denial	Sublimation
Idealisation	Displacement	
Passive-aggression	Dissociation	
Projection	Externalisation	
Projective identification	Identification with the aggressor	
Splitting	Intellectualisation	
	Reaction formation	
	Regression	
	Repression	
	Reversal	
	Somatisation	
	Undoing/doing	

Primitive mechanisms

Splitting

Following Klein, contemporary psychoanalysts use the term "splitting" to refer to the ways in which people tend to divide the world and their "objects",

internal and external, into "good" and "bad". According to this model, children, in their minds, split their mother into two separate persons: the bad, frustrating, hated mother, and the good, idealised, loved mother. By mentally keeping the good and the bad mother strictly separate, the ambivalent conflict between loving and hating someone who is, in reality, one and the same person, who is a mixture of good and bad, is avoided. In splitting, complex and contrary experiences cannot be held in consciousness at the same time, or at least not in relation to the same object. Thus, love and hate are not necessarily fully repressed, but oscillate, unable to be active and conscious at the same time.

Splitting in adulthood is manifest when an individual finds it difficult to live with ambivalence and uncertainty. This may be particularly evident when, in stressful situations, feelings become intensified. The ability to see complexity is reduced and schematic understanding dominates. Inevitably, this can lead to extreme views. The capacity to generate differentiated representations of others, and to respect their different goals and beliefs, is lost. Representations become fixed – "if you are not with me, you are my enemy". Decision-making becomes impaired, while self-definition and self-esteem are dependent on always being "right" and others being in the "wrong".

Example: The envied siblings

A patient experiencing depression, one of four children, continually complained that her mother had neglected her and favoured her siblings. She repeated stories of her mother's favouritism and unceasing concern for her sisters and brothers, from whom she was now estranged. Likewise, she decided that her analyst was kinder and more helpful to his other patients than he was to her. Consumed with envy, she started to wait outside his consulting room, asking other patients whether they were seen more frequently than she was. In the sessions themselves, she felt OK, but could not understand why the moment she left the consulting room, she began to feel that the analyst hated her and cruelly withheld the help he willingly gave to others. This was a stark example of splitting. Outside the sessions, she could see him only as someone who was cruel and neglectful, while within sessions she experienced him as ideal, caring, and thoughtful. Despite the near-psychotic flavour of this splitting, it meant at least that the "good" analyst stayed safe from her envious attacks.

Klein also recognised that, since internal and external objects exist in relation to the self, or ego, a concomitant split in the ego may also occur – that is, a resonating "good self" and "bad self". This is in keeping with Freud's later use of the term "splitting". He referred to a "splitting of the

ego" in fetishism, allowing a quasi-psychotic simultaneous holding of contradictory ideas (Freud, 1927). The split coincided with the contradiction between a wishful fantasy and a reality, rather than between object representations – "the instinct is allowed to retain its satisfaction *and* proper respect is shown to reality" (Freud, 1940, p. 274) (our italics). Freud's use of the term was perhaps influenced by Bleuler's (1924) account of supposed "loosening of associations" in schizophrenia – that is, failures of reality testing.

However, splitting is now viewed, especially from the Kleinian perspective, as a *primary phenomenon of mental life* in infancy, potentially contributing to the development of borderline and psychotic disorders later in life (Kernberg, 1975). In these cases, splitting is extreme and leads to a distortion of perception, a diminution in the capacity to think about feelings, and fragmentation of objects.

But, if seen as an aspect of categorising and selective attention, splitting can be benign as well as pathological. The ordering of the internal world relies on a degree of splitting. Good splitting (a phrase that illustrates its very necessity) is thus a precondition of later integration and the basis of the faculty of judgement (Segal, 1973). In this aspect, it has similarities to Freud's (1909) concept of negation. The widespread tendency to split the world into good and bad, right and wrong, black and white, or heaven and hell persists throughout life, and profoundly affects our attitudes not only to individuals but also to social institutions and political, religious, and other organisations.

Projection, identification, and projective identification

Klein's "discovery" of projective identification in psychoanalysis has been compared with the discovery of gravity or natural selection (Young, 1994). Projective identification is an important but complex concept, partly because of its inherent difficulty, partly perhaps because its name is misleading, and partly because, as one of the fundamentals of Kleinian psychoanalysis, it provokes political controversy disproportionate to its clinical role and relevance.

The notion of *projection* is relatively straightforward and has entered the vernacular of "folk psychology" (Bruner, 1990). The depressed young man lying on a beach who stated "Everyone on this beach looks utterly miserable" was clearly attributing to others his own affective state. We commonly attribute our more difficult and unacceptable feelings to others – for example, blaming those who are close to us for our own shortcomings. Externalisation, the outward limb of projection, allows us to disown responsibility and thus to evade guilt and disappointment. But, if ingrained, it can reposition the "locus of control" (Rotter, 1966), leading to chronic victimhood, a sense of limited agency, and evasion of the influence we have on the fabric of our lives.

Sometimes, when unwanted impulses and feelings boomerang back, the result is a feeling of being under constant attack. Here, the projection has gone full circle and leads to anxiety or, if extreme, paranoid delusions.

Identification, similarly, is relatively straightforward, referring to the process by which self-representations are built up and modified during development. The little boy who shuffles around in his father's shoes is simply imitating, but as his internal image of himself is influenced and later transformed into a personality characteristic, identification has occurred, especially if he eventually "steps into his father's shoes" and takes over the family business. Piaget's (1954) digestive metaphors of "accommodation" (akin to imitation, where someone "tries on" the characteristics of a mentor) and "assimilation" (more like identification), which refer to the cognitive processes of incorporating the other's characteristics into the self, are similar.

As Klein (1946) originally conceived it, projective identification combines these two notions in a highly specific way. She described projective identification as a phantasy in which bad parts of the infantile self are split off from the rest of the self and projected into the mother or her breast. As a result, the infant feels that his mother has "become" the bad parts of himself. Of particular importance is, first, that the projection is "into" rather than "on to" the object – prototypically the mother or the analyst – and, second, that what is projected is not so much a feeling or an attitude, but the self, or part of it. Thus, Klein imagined that in the "paranoid–schizoid position" the infant projects "bad", sadistic aspects of himself into the mother's body. The purpose is to rid the self of its own toxicity and at the same time to control and injure the mother from within. If these bad part-objects are then re-introjected – via "introjective identification" – the individual contains within him/herself a "bad" identificate, a nidus of low self-esteem and self-hatred. Meanwhile, "good" parts of the self may also be projected and re-introjected, increasing self-esteem and enhancing good object relations – but in manic states these lead to omnipotence and grandiosity.

In this original formulation, projective identification was defensive, intrapsychic, and solipsistic, a mental transaction involving the self and a perception, but not the participation, of the other. How then does projective identification differ, if at all, from projection? Klein, herself, was clear about this. Projection is the mental "mechanism" underpinning the process, and projective identification is the specific phantasy expressing it. Spillius (1988a) suggests that projective identification adds depth to Freud's original concept of projection by emphasising the way that in it projection is accompanied by a projection of parts of the self.

Spillius notes that British authors rarely consider the distinction between projection and projective identification to be of particular importance. In contrast, many American writers have devoted a great deal of discussion to the topic (Langs, 1978; Ogden, 1979), often distinguishing projection and projective identification by whether or not the recipient of the projections is

emotionally affected by the phantasy. In projective identification, the recipient's actions and feelings are shaped – or even controlled – by the projective process. Thus, the analyst of a patient whose main trauma was childhood neglect finds herself "forgetting" an appointment, thereby enacting the patient's phantasies of abandonment and retaliatory mental ablation. In projection, by contrast, the targets of the projections may be blissfully unaware of and unaffected by their role – as, no doubt, were the holidaymakers on the beach in the example given above. The paranoid person projects malevolent intentions on to politicians, pop stars, royalty, and so forth, with whom he never comes into contact, or indeed on to inanimate objects.

The distinction between projection and projective identification rests on Klein's emphasis on the *communicative* aspect of the latter, which encompasses three separable theoretical formulations. First, if projective identification is an interactive and interpersonally dynamic phenomenon, then the recipient of the projection, as mentioned earlier, may be induced to feel or act in ways that originate with the projector. This accounts for the realisation first described by Heimann (1950), and later Grinberg (1962) and Racker (1968), that countertransferential feelings evoked in the analyst often reflect aspects of the patient's inner world. As mentioned earlier, these ideas, often in a diluted form, have become widely accepted in psychodynamic circles: if the analyst is feeling bored, irritable, or sad, these feelings may, via projective identification, originate with the patient. Here, the "identification" is occurring within the target of the projective identification rather than, as Klein first saw it, within the projector (i.e., as a "misperception").

Second, Ogden (1979) argues that "identification" is a two-way process that occurs within both projector and recipient, although Grotstein (1983, 1984) and Kernberg (1987) disagree. For Ogden, it reflects a mutual process in which projector and recipient interact with one another at an unconscious level. The analyst who is unaware of the feelings induced in him by projective identification may enact them by, for example, being rejecting or sluggish in the session – feelings that may, in turn, be picked up on by the patient. This aspect was operationalised as part of cognitive analytic therapy by Ryle (1985; Ryle & Kerr, 2002), who considered projective identification as a particular form of *reciprocal role procedure* in which a responsive interaction is set up between a patient and others. Identifying these reciprocal roles (neglected/neglecter, etc.) is an important part of the initial clinical assessment, as is recognising the pattern when it is activated in therapy.

Spillius (1994) coined the phrase "evocatory projective identification" to describe this pressure put on to the analyst to conform to the patient's phantasy. The Sandlers (Sandler, 1976a, 1976b; Sandler & Sandler, 1978) see this aspect of projective identification in terms of "actualisation" and "role responsiveness", in which the analyst has to be flexible enough to respond slightly to the role in which he is cast

by the patient's projective identification, while also remaining sufficiently centred in himself to observe and interpret this process as it happens.

The ramifications of the communicative aspects of projective identification are so great that it can eventually cover almost all that happens in the analytic situation. However, it is clinically mistaken to assume that everything that the analyst experiences is a result of what the patient is "putting into" him. It is important to distinguish between "patient-derived countertransference" and "analyst-derived countertransference" (see Chapter 5), however difficult in practice this may be (Money-Kyrle, 1956). The former is based on projective identification, whereas the latter most definitely is not.

The third extension of the projective identification concept derives from Bion (1962, 1963). Klein saw projective identification primarily in negative terms: the projection of sadistic feelings as part of the paranoid–schizoid position. Bion realised that there was also a "positive" form of projective identification underlying empathy and the processes by which the mother contains projected painful and hostile feelings, "detoxifies" them, and returns them to the infant in a more benign form at a phase-appropriate moment. However, some of Bion's clinical uses of the idea of projective identification remain controversial. He advocated speaking to psychotic patients in concrete ways; thus, he might say "You are pushing your fear of murdering me into my insides". While this kind of interpretation may occasionally be successful, in inexperienced hands it can be at best incomprehensible and at worst dangerous, and as a standard technique it has been much criticised (Sandler, 1987). It is rarely used now, but Lucas (1993) outlines the necessity for the clinician to "tune in to the psychotic wavelength" and to talk to patients about their psychotic experiences in ways that accept rather than challenge their psychotic reality.

Despite these extensions and mitigations, the fundamental projective identification concept is as a method of control of the object and of unmanageable feelings. Here, facets of the ego are split off and projected into another person, creature, or even one's own body, all of which then represent and become identified with the split-off parts; attempts are then made to survive by controlling these split-off parts of the self by asserting control over the other person, or by attacking one's own body, as in deliberate self-harm and eating disorders (Motz, 2010).

Example: The controlling teacher

A man in his late twenties was working as a probationary teacher and was put in charge of a class of adolescent boys; he soon began to resent any boy who was badly behaved, so much so that he became

frightened before each lesson lest he would be unable to control the class. Predictably, the class did indeed become increasingly disruptive. The sufferer began to hate his pupils and feared that he might lose control and hit one of the boys.

During analysis, it emerged that throughout his own adolescence he had been an exceptionally "good boy" – obedient, hard-working, and never causing trouble either at school or at home. He had split off all the destructive and rebellious aspects of himself that, as a result of his upbringing, he considered to be dangerous and unacceptable. Projective identification meant that he was now projecting all these unacceptable aspects of himself into his adolescent pupils. They had become identified with his own split-off rebellious parts. He feared these unwanted aspects of himself and desperately but unsuccessfully tried to reassert mastery over them by trying to control and punish his pupils.

During a psychoanalytic session, he recalled that as a boy he used to collect and play with toy animals – tigers and crocodiles – making them attack and devour other animals and human beings. It was no great leap for him to see that these toy creatures embodied the projected aggressive parts of himself, and that by projecting and disowning them he had lost an inner sense of being strong enough to stand up for himself and to fight other boys and, later, his pupils.

The combination of unconscious splitting off aspects of the self and projecting them is often described psychoanalytically as "psychotic thinking". In this psychoanalytic conceptualisation of psychosis, the cognitive and emotional boundaries between self and others become porous. This leads to misinterpretation and misunderstanding of self, self-in-relation-to-others, and others-in-relation-to-self. Based on projective identification arise persecutory delusions (whose origins lie in projections of a person's own "bad" thoughts) or hallucinatory phenomena, in which sensory-affective experience is not shared or "checked out" with others, whose experience is discounted or mistrusted, leading to rigid states of psychotic certainty.

It is important to note that good aspects of the self can also be projected into others. Projective identification can thus leave an individual feeling deprived of essential aspects of his own personality, both good and "bad". A central task of analysis is to help the patient recover these lost aspects of the self. Projective identification is therefore important because it tackles the lifeblood of psychoanalysis – the interplay of phantasy in intimate relationships. It is both defensive and communicative, and the style and responsiveness of the analyst may be the primary factor in determining which

aspect is uppermost (Joseph, 1987). Defining and naming the concept in a meaningful way is "difficult" because it originates in a rather casual definition given by Klein (1952) and retains a title that does not really capture post-Kleinian extensions. Although "communicative projection" or "projective interaction" may be preferable expressions, Spillius (1988b) suggests that "projective identification" should be retained as a general term within which various subtypes can be differentiated. The many motives behind the process – to control the object, to acquire its attributes, to evacuate a bad quality, to protect a good quality, to avoid separation, to communicate – may be useful starting points to identify subtypes.

Neurotic mechanisms

Denial and disavowal

Repression has already been mentioned as the primary mechanism of defence during development, which enables the child to maintain a balance between internal wishes and the constraints of the external world without being exposed to excessive psychic pain. However, later in life, when used excessively, it leads to dissociation of aspects of emotional life from consciousness and, as in Freud's original ideas, according to classical theory, leads to the formation of symptoms such as the "*belle indifference*" associated with hysteria.

In contrast to repression, which aims to remove an aspect of internal reality from consciousness, denial or disavowal (Freud, 1940) deal with external reality and enable an individual to repudiate or to affectively control his response to a specific aspect of the outside world. Denial involves splitting, in which there is cognitive acceptance of a painful event while the associated painful emotions are repudiated. Denial is an integral part of the bereavement response, in which the sufferer may argue that the lost loved one is not dead, but merely away on a long journey. This can shade over into disavowal, where the death is partially faced, but a bereaved spouse might continue to lay a place for their loved one at mealtimes, or a parent might preserve a dead child's bedroom as a shrine.

Weintrobe (2019) uses the disavowal concept to explain climate change denial in which one simultaneously accepts the scientific evidence for global warming but continues to fly in aeroplanes, burn fossil fuels, eat meat, and so on.

Reaction formation; identification with the aggressor

The term "reaction formation" captures those situations in which people adopt a psychological attitude diametrically opposed to their unconscious wishes or desires. Reaction formations often appear during early adolescence

and act as a bridge to more mature defences such as sublimation. Reaction formations may be highly specific – for example, showing excessive deference to some person one hates, or caring for others when one wishes to be cared for oneself – or more generalised, in which case they form part of a character trait. As with all defensive pathologies (as opposed to adaptive defences), reaction formations alter the structure of the ego in a permanent way, so that the defence persists even when the danger is no longer present.

Although Freud (1920) alluded to "identification with the aggressor", and Ferenczi (1933) had used the term to describe the behaviour of a child who submits to an adult's (usually their caregiver's) aggression, as mentioned earlier, it was Anna Freud (1936) who described the mechanism in detail and related it to the early formation of the superego. Identification with the aggressor has links with both reaction formation, in that there is a "reversal of affects", and identification, and can even be seen as a subtype of projective identification.

Example: The unassuming lawyer

This quietly spoken and timid patient was, he reported, frequently threatened, humiliated, and beaten during childhood by his father. Prior to being beaten, he would run away to his room while his increasingly angry father chased him. After the chase, the little boy would suddenly go quiet and bend over, and his father would then beat him, while he remained completely silent and entered a dissociated state. At this moment, the boy had dis-identified with his self-representation and identified with his father (the aggressor) who was going to beat his naughty, bad body. In adult life, the patient continued the identification with the abusive father by clandestinely taking illegal drugs and cutting himself, thereby allowing both the abuser and the abused to continue living out their interaction through his mind and body.

Identification with an aggressor inevitably disrupts self-organisation. The abusive intention is now incorporated as part of the self, however alien it may be. This may lead to self-destructive actions, as in the example. These processes are significant in persistent childhood trauma. Such children may learn to subjugate themselves to others, becoming biddable and compliant as ways of surviving. The self-reflective part of the mind is closed down and identification with the aggressor is complete. Psychoanalysts need to be alert to this process being repeated in the transference (e.g., in patients who are excessively compliant) and then to bring it into consciousness so that it can be thought about and countermanded.

Isolation and undoing

Freud first described isolation as a distinguishing feature differentiating hysterical conversion from obsessional neurosis (Freud, 1892). He suggested that if painful affects were not "converted" via repression into bodily symptoms, then the affect could be "neutralized" by isolation, thereby rendering the sufferer immune to its painful impact. But, while the affect was rendered unconscious, the associated idea, stripped of feeling, remained conscious.

This contrasts with repression, in which the "idea" – a concept, a memory, or an image – rather than the affect is banished from consciousness, and also with dissociation, in which affect and idea both remain conscious but the links between them are severed, again as a self-protective strategy. In isolation, a traumatic memory is accessible to awareness, but is denuded of any feeling. Thus, patients who have recently taken an overdose or cut themselves often talk about the circumstances leading up to the event with considerable calm, and may induce a false sense of ease in the assessing doctor. This is now seen as an example of pre-mentalising "teleological thinking" in which events follow one another in sequence but the agency and involvement of the actor is removed (Bateman & Fonagy, 2019). Thus, the sufferer is "isolated" – from both their actions and their feelings.

Undoing is often referred to as "doing and undoing" or "magical undoing" and is typical of the compulsions seen in obsessive–compulsive disorder (OCD). Undoing enables sufferers to reverse – in their minds – repudiated libidinous or hostile wishes, which they believe they have already perpetrated in the "doing". Thus, a binge eater might succumb to greedy ingestion of sweet foods, followed by guilty attempts at self-purging to undo their unregulated desire. People with OCD may feel compelled to carry out actions – for example, when getting dressed or before leaving home – in a ritual way to forestall danger, only to have to repeat the whole procedure if one component is missed. These attempts to "undo" have a magical or omnipotent quality, aiming to reverse time, negate the reality of the original hostile thought or wish, and recreate the past as though such intentions had never existed. To return to Freud's original hysteria/OCD dichotomy, one might say that in hysteria the sufferer is overwhelmed with unregulated affect, which is transformed into physical symptoms, whereas in OCD there is excessive regulation of repudiated affect.

Internalisation and incorporation

Internalisation is a supraordinate term that subsumes introjection, incorporation, and identification and refers to all the processes by which the individual builds up his inner world by taking in and modifying the external objects and relationships. Introjection is integral to the healthy oedipal

journey in which children overcome their feelings of envy and exclusion from the parental couple by identifying with the same-sex parent, and consoling themselves with the thought that in doing so, their turn will eventually come. This process continues through the life cycle, when young people become parents for the first time and finally identify with introjected parental attitudes in their approach to their child. Introjection has an important role to play in the formation of the superego, in the sense that one's values are largely derived from introjection of parental attitudes, or sometimes in direct opposition to them (as in "negative identification"), or a mixture of the two.

Freud's insight that one can deal with separation and loss by "becoming" the person whom one has lost was developed by Klein in her concept of "identification with the lost object" (Klein, 1955). She saw this as part of the normal mourning process. A widow may "feel" her husband's presence within her, or talk to him for consolation or advice at times of sadness and difficulty. If carried to excess, this may form part of denied or delayed grief and bereavement.

The Piagetian processes of accommodation and assimilation help us to understand the ramifications of identification. In normal introjection, the person "digests" aspects of their identificate and makes them their own. Incorporation, by contrast, is the psychological correlate of eating and refers to the "swallowing whole" of an identificate without modification or assimilation, and can have a psychotic flavour.

Example: Identifying with parental negative image

A 45-year-old woman with BPD characterised by severe bulimic symptoms cut herself and attempted suicide on numerous occasions. She exercised excessively, cycling at least 10 miles a day and swimming a mile in the evenings. Her fantasy when exercising, cutting, and inducing vomiting was that all the "evil things" were being expurgated, and it was especially relieving to her if the vomit had streaks of blood in it. Indeed, she believed that the only way to find absolute calm and tranquillity, and to be released from everything inside her, was if she stuck a knife into her body to see all the red evil things gush out of her insides. She said that her mother had repeatedly called her a selfish, wicked girl, and how as a child she would continually pray that it was not true. This helped her to feel less wicked. But her mother's view of her remained within her as a non-assimilated incorporated object. Although prayer and various attempts at "undoing" momentarily helped, they never fully resulted in a change in her self-representation. Only when she could accept the angry, rejected, yearning aspects of herself did her self-destructive acts diminish, as the maternal introject began to dissolve.

Intellectualisation and rationalisation

Intellectualisation and rationalisation are ubiquitous in politics, business, and medicine – and psychology. They bridge the gap between immature defences and those of maturity, and persist into adult life without leading to any overt problems. Intellectualisation covers a range of subdefences, including thinking instead of experiencing, and paying undue attention to the abstract to avoid intimacy. For example, the adolescent, fearful of his developing sexuality, may talk intellectually about premarital sex or earnestly discuss the sexual behaviour of young people. Rationalisation similarly offers logical and believable – and truthful – explanations for irrational behaviours that have been prompted by unconscious wishes. Thus, one might rationalise a fear of oedipal rivalry and competition by saying that exams are a waste of time, and do not measure the things that really matter about a person.

Mature mechanisms

Sublimation and humour were honoured by Freud as mature defence mechanisms for their capacity to allow partial expression of underlying wishes and desires in a socially acceptable way, while simultaneously enriching society. In sublimation, wishes are *channelled* rather than dammed up, denied, or diverted. Aggressive urges find expression in games and sport; in the arts, feelings are acknowledged, modified, and directed towards significant goals; narcissistic needs might be fulfilled by harmless "showing off", cracking jokes, or becoming a successful actor.

Example: The paint pot and the palette knife

A 50-year-old engineer and amateur artist entered analysis due to treatment-resistant depression after he had been made redundant by a company to which he had devoted the best years of his life. He had never known his father, who had been killed in the war, and had grown up as an exceptionally controlled and "good" boy who had devoted himself to his widowed mother. She remarried when he was 7 years old, and he submitted without murmur to his stepfather's harsh discipline. He prided himself on never losing his temper. He had married a subservient wife. On one occasion near the start of his depression, while he was decorating the house, she supplied him with the wrong sort of paint. To his horror, he found himself simply upending the entire 5-litre tin on to the floor and walking out of the house, leaving her to clear up the mess. As the analysis progressed, he began to get in touch with deeply suppressed feelings of longing for

closeness and intimacy, and anger that no one realised what he really wanted. Later, to his surprise, he resumed painting, but instead of the meticulous line drawings he had done in the past, he began to smear paint thickly with a palette knife directly on to the canvas. His need for emotional expression, earlier a rageful manifestation of depression, was now sublimated into life-enhancing creativity.

Freud saw sublimation as the vehicle by which a society's basest and deepest desires, as well as aspirations and ambitions, gain expression – through carnival, drama, music, poetry, and religious and political aspirations. Likewise, humour allows us to "ventilate" and share emotions, often aggressive ones, without discomfort, to regress without embarrassment, to play games with freedom, to laugh with impunity and relax with pleasure, and may at times allow terrible tragedy to become bearable. Helping a patient to laugh – in a genuine rather than defensive way – is often a mark of real progress in psychotherapy.

Research

Vaillant and colleagues have confirmed the adaptive value of mature defences (Vaillant, 2011; Vaillant, Bond, & Vaillant, 1986; Vaillant & Drake, 1985). Their longitudinal studies of men, who were followed from their high-school graduation over a 40-year period, show that those with mature defences were consistently happier, and more successful and stable occupationally and in their family lives, than those using less mature defences. Similarly, Perry and Cooper (1989) found that immature defence mechanisms are associated with psychological symptoms, personal distress, and poor social functioning.

Important as these studies are, the findings do not differentiate the causative role of defences from the developmental processes that may have instated them. Nevertheless, Sartorius, Jablensky, and Regier (1990) suggest that mainstream psychiatry's efforts to link symptoms, causal factors, pathogenic models, and prognostic types have generally failed. They argue that the return of "…allegedly outdated Freudian defence mechanisms is warranted". This comment emphasises the continuing importance of psychodynamic contributions to psychiatric diagnosis and argues for the consideration of defences as higher-level psychological processes that should be part of the transdiagnostic approach to mental disorder.

Reliable measurement of many of the defence mechanisms is now possible with scales that primarily take a hierarchical approach to defence, identifying primitive/immature and mature mechanisms. Haan's Q-sort of Defending and Coping Processes (Haan, 1977) asks coders to rate semi-structured interviews asking about respondents' present lives and past

experience; the Defence Mechanism Rating Scale (Perry & Henry, 2004) uses transcripts and videotaped discussions to determine levels of use of immature and mature mechanisms of defence.

The findings about the relationship between defence mechanisms and pathology are consistent: more immature mechanisms are associated with more symptoms and behavioural disturbance. In intimate partner violence, the frequency of devaluation, idealisation, and omnipotence – that is, immature mechanisms – is linked to the severity of physical and psychological aggression. Looking at the impact of psychotherapy on defensive constellations, Johansen, Krebs, Svartberg, Stiles, and Holen (2011) found that changes in defensive function in Cluster C personality disorders significantly predicted improvement; in a comparable study, Bond and Perry (2004) found a significant effect for the relationship between overall maturation in defences and decrease in depression in psychoanalytic psychotherapy.

These findings raise the question of the direction of causation. Does immaturity of defences lead to poor social function and psychological illness, or vice versa? It will be important to work out the temporal relationship between changes in defensive function and changes in symptoms: which comes first? It is possible that a reduction in symptoms allows for more mature organisations, rather than the other way round. A reduction in acute symptoms may allow the mobilisation of more adaptive defences, but equally it is possible that embedding mature defence mechanisms, and their adaptive use, precedes resilience to stresses in daily life.

Whether cause or consequence, modifying defences helps with achieving the elusive balance between identity, autonomy, and relatedness to others that is necessary for constructive living. Given the centrality of defences in the psychoanalytic model of treatment, this may account for some of the rehabilitative and long-term improvements it can produce.

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Chapter 5

Transference and countertransference

> Transference, which seems ordained to be the greatest obstacle to psychoanalysis, becomes its most powerful ally. (Freud, 1905, p. 116)

"Übertragen", or transference, was first developed by Freud to account for the ways in which "psychic energies" might be diverted to produce illness. Next, he saw it as underlying the dissociation and "false connections" seen in hysteria. Then, based on the Dora case (Freud, 1905), he arrived at a psychoanalytic model, as described in his autobiographical study (Freud, 1925, p. 42):

> In every analytic treatment there arises, without the physician's agency, an intense emotional relationship between patient and the analyst which is not to be accounted for by the actual situation. It can be of a positive or negative character, and can vary between the extremes of a passionate completely sensual love and the unbridled expression of an embittered defiance and hatred. This transference – to give it its short name – soon replaces in the patient's mind the desire to be cured, and, so long as it is affectionate and moderate, becomes the agent of the physician's influence, and nothing more nor less than the mainspring of the joint work of analysis.

Key themes in this eloquent account include the following:

1. the displacement of symptoms, as the main focus of treatment moves to the therapeutic relationship itself;
2. disconnecting the emotional aspect of the therapeutic relationship from the "actual situation";
3. transference as negative or positive;
4. the role of the therapeutic alliance; and
5. transference as "joint work", and thus co-constructed.

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Psychoanalysis differentiates itself from the other psychotherapies primarily through its use of transference and countertransference. But what precisely *is* transference, and how does it relate to the different models of the unconscious? Once more we come up against the elasticity of psychoanalytic concepts discussed in the previous chapters. We have seen how variations between psychoanalytic models of the mind inform different ways of working with patients. To put it schematically, interpersonal approaches describe transference in terms of a two-person interaction, with contributions from both analyst and patient; ego psychology considers transference as manifesting instinctual wishes; and a Kleinian perspective points to the role of unconscious phantasy in determining how the analyst and the analytic situation are experienced. There is, however, general agreement about the existence of transference as a phenomenon; the main debate concerns its content – that is, what exactly is "transferred". There are also important differences of opinion about the centrality or otherwise of transference interpretation as the only truly effective therapeutic intervention. Clinical considerations of transference are discussed in Chapter 9; here, we shall discuss more theoretical issues. Although transference and countertransference are inextricably linked, they will be considered separately.

Transference

Breuer and Freud (1893–1895) initially saw transferences as "contaminating influences" that interfered with or resisted Freud's cathartic method. Freud was worried that they were a result of the doctor's undue influence on the patient and, if overemphasised, psychoanalysis would be seen as a modified form of hypnosis or "suggestion". But Freud soon decided that transferences did *not* arise solely out of suggestion (i.e., were primarily therapist-induced), but were an expression of oedipal feelings towards the analyst that replayed the individual's earlier relationship to parental figures (Breuer & Freud 1893–1895; Freud, 1905). This led to the idea that there could be a *transference neurosis* (Freud, 1914), comprising positive and negative transferences paralleling the affects and wishes surrounding the original oedipal situation, now re-enacted within the analysis itself. Analysis of the transference neurosis then became a *requirement* for an effective analytic cure, as it would otherwise act as a resistance to the remembering of repressed phantasies. Thus, very early on, Freud hit on transference's dual aspect: on the one hand, a resistance to verbalised recollection, on the other, a therapeutically useful "re-presentation" of infantile conflict.

Freud (1912) also distinguished between transferences that reflected past experience and those that are aroused in the present situation. Using a printing metaphor, Freud differentiates the *mechanisms* of transference – "templates" or "reprints", that is, infantile images in the system unconscious – from the *dynamics* of the patient's current emotional relationship with the

analyst – "new editions". This double aspect of transference continues in the debate among contemporary psychoanalysts between the relative importance of the "past unconscious" and "present unconscious" (Sandler & Sandler, 1984). Some authors see transference as the main route to the reconstruction of childhood trauma; others see exploration of the here-and-now transference as central. Similarly, there is a debate between those who take an intrapsychic view of transference and those who emphasise the interpersonal aspects. Whatever view is taken, transference, which eventually occupied a pivotal role in Freud's clinical theories, continues to be the central theme of contemporary psychoanalysis.

Transference interpretation: classical and modern

To compare different aspects of transference, we shall use a somewhat artificial contrast between "classical" and "modern" (or "contemporary") practice and thought. The most straightforward "classical" definition of the dynamic aspect of transference may be summarised as a process by which the patient transfers on to his analyst past experiences and strong feelings – dependency, love, sexual attraction, jealousy, frustration, hatred – that is, residues of childhood feelings towards his mother, father, or siblings. The patient is generally unaware of these "false connections". Analytic work on transference reveals and allows the re-experiencing or reconstruction of the past, and, once insight into it has been achieved, helps the patient to overcome past trauma. In this model, the ambiguity of the analyst is positive in that it evokes the projection of infantile wishes, but transference is also a potential resistance to understanding and therapeutic progress.

By contrast, the "modern" view sees transference as the emergence of latent meanings, organised around and evoked by the intensity of the analytic relationship. Therapeutic benefit entails examining how the detail of present-day wishes, character formations, and personal expectations are shaped by the past. Infantile neurosis is not seen as the sole explanation for adult pathology, nor is deconstruction of the transference neurosis viewed as a simple pathway to cure. Rather, transference is a medium through which the individual's internal drama is played out with the analyst: a new experience shaped by the past but not a straightforward repetition (Cooper, 1987a, 1987b).

Brenner (1982) believes that the term "transference neurosis" is redundant and should be dropped. Not all authors agree (Wallerstein, 1994): there are undoubtedly some patients for whom analysis assumes increasing salience and in whom, as treatment progresses, neurotic difficulties disappear from their outside life but still loom large within the therapeutic situation. Garland (1982), in a group analytic context, describes this replacement of symptoms with transference phenomena as requiring the analyst to "[take] the non-problem seriously" – that is, once the problematics of the analytic

Table 5.1 Classical and modern views of transference

	Classical	*Modern*
Definition	Displacement of past into present shaped by experience	Organise present experience according to internal models
Reality	Distortion – objective reality	Subjective reality
Motivation	Aggressive/libidinal drives related to infantile wishes, phantasies, fears	Adaptive; organising perceptual/ affective/cognitive experience necessary for cohesive self
Analyst	Neutral/blank screen; objective	Contributes through interaction; subjective
Intervention	Interpretation of distortion	Reflects patient's construction and how he/she organises analytic relationship
Change	Decrease in infantile wishes and less distortion	Rigid psychological schemas become flexible; new ones emerge as a result of analytic experience

relationship come to the fore, while presenting symptoms lose their initial salience.

The classical and modern views of transference interact in a complex way, as summarised in Table 5.1.

Three key questions have preoccupied contemporary theorists:

1. Is transference a distortion of reality or a valid representation of a present unconscious situation coloured by past experience?
2. Is transference a general or a specifically analytic phenomenon?
3. Does transference encompass the whole or only part of the analytic situation?

Distortion or reality?

From a classical point of view, psychoanalysis sees transference as a distortion of reality, as the patient's infantile wishes push for gratification. A contemporary view would be that transference entails a complex mosaic of past and present.

Example: The unappreciative analyst

Bryony complained that her analyst did not seem to appreciate how hard she worked and did not seem to care how she was getting on in her job. The analyst tentatively suggested that she was unconsciously accusing him of failing to appreciate how hard she worked in the

"job" of analysis or care about how she was progressing. Bryony then described how her mother had had a successful career early in her life but gave up work when Bryony was born. She felt that her mother resented her academic success and took little interest in her schoolwork, self-centredly saying only that she wished *she* could return to work herself. The analyst wondered if Bryony perhaps thought that her success would lead to envy and resentment in others, and therefore that, like her mother, the analyst might also be resentful of her success – in and out of the consulting room.

This example shows the complex mix of classical and modern approaches used in everyday clinical practice. The analyst's first interpretation was "modern" in that he linked outside material with the transference relationship, finding hidden meaning in the patient's reference to her job as an allusion to the analytic relationship. The second was classical in that the patient's past relationship with her mother was seen in a fairly straightforward and perhaps unsubtle way as distorting her perception of the analyst.

From a modern point of view, Bryony's annoyance with the analyst is seen as representing a *current* wishful fantasy or expectation, inaccessible to consciousness and therefore needing a "transference interpretation" to bring it to light, but linking only indirectly with the earlier failures of the mother. "You don't appreciate me" is a here-and-now living affect of resentment and wistfulness, anger and longing, rather than an anachronistic dead letter. The fantasy as enacted with the analyst is the first focus of interpretation, while the infantile constellation from the past becomes a later consideration. Transference is now conceptualised as an interactive process in which the patient responds to selected psychologically relevant aspects of the analytic situation, arising out of – but far from fully determined by – past developmental experience.

No doubt the patient's perception of the analyst is to an extent driven by the past: one patient may see her as a beautiful, caring, and understanding angel, whereas the next sees her as a hostile and rejecting witch. We see and experience what we expect to see. The deliberate ambiguity of the analytic stance is designed to bring transferential wishes and preconceptions into view. As originally conceived by Freud, transference was a *resistance* to understanding, impeding understanding and progress. Only later did he see how transference could be used to reveal aspects of the patient's inner world. But, although ambiguity is an integral part of the analyst's role, no analyst is ever a fully blank screen. Consciously or unconsciously, patients cannot *not* perceive and assimilate aspects of the analyst's reality – the way she arranges and decorates her room, wears a wedding ring, runs her practice, takes breaks, and so on. Therapeutic "reality" is co-constructed, and a significant

part of the analyst's work is teasing out and attributing ownership to the differing proportions of transference and countertransference that make up the fabric of their present-moment relationship.

An implication of some approaches is that there is a pristine truth or internal "psychic reality", made accessible through interpretation of defences and/or unravelling of distortions. This Platonic view is prevalent among object relations and neo-Kleinian analysts (Kernberg, 1987; Steiner, 2018). Others (Gill, 1982; Schafer, 1982; Spence, 1982) see the transference relationship more as a personal *narrative truth* rather than as a distortion of psychic reality. For them, validation of this personal story is a precondition of analytic work. This view is also supported by interpersonal analysts (Aron & Leichich, 2011; Benjamin, 2004; Mitchell & Aron, 1999). The *nachträglichkeit* discussed in Chapter 3 suggests that the very notion of "the past" is a contemporary construction, at least in the sense that the feelings associated with an event are coloured by a person's here-and-now situation.

These modern views of transference as the emergence of latent meanings allows it to be seen in a positive light. Transference is not just an insight-generating representation of the past, but a *probe* on the part of the patient, unconsciously aiming to elicit responses from the analyst that bring the patient's developmental needs to the fore. Slavin and Kriegman (1992) argue that it is unlikely that evolution would have produced a mind beset by continual misperceptions and distortions. Instead, they suggest an adaptive view of transference in which it brings together learned experiences with novel ones, so that previous experiences may be revised in the light of new ones. Neuroscience supports this view (Carhart-Harris & Friston, 2010; Holmes, 2020). Seen this way, transference becomes an "earlier version" awaiting revision rather than a pathogenic distortion of the present situation. Psychological illness is linked to transference only insofar as this revision process is inhibited by repression, or over-adherence to prior models of the world. From an existential perspective, Stolorow, Brandchaft, and Atwood (1987) suggest that transference is the way in which we use unconscious organising principles to understand life around us. Comparably, Bollas (1987), in his coinage of the "unthought known", sees transference as not merely a reliving of an earlier relationship but a fundamentally new experience in which elements of psychic life that have not been previously "thought" are being given time and space for the first time.

General or specific?

At one stage, controversy raged as to whether transference arose only in the therapeutic situation (Waelder, 1960) and the analytic relationship (Gill & Hoffman, 1982) or played a part in relationships in general. Today's consensus is that transference influences all relationships, including our attitudes to institutions. For example, someone who repetitively reacts to his

employing organisation in a combative and aggressive way may be reliving unresolved battles with his father. Similarly, hospital patients, sensitised to real defects in care, may feel let down in ways that were prefigured by a busy, distracted mother. Nevertheless, the analytic situation clearly intensifies the development and observation of transference phenomena.

All or part?

More problematic is the question of whether all or only part of the analytic process can be understood as transference. There have been as many attempts to narrow the definition of transference as there have been to broaden it. Anna Freud (1936) wanted to confine transference to three aspects: transference of *libidinal impulses*, transference of *defences*, and "*acting in* the transference". These different aspects of the transference all follow the classical approach in which earlier infantile wishes and defensive manoeuvres or actions are repeated in the present. "Enactment" (Jacobs, 1986) can occur in the session itself or in the patient's outside life, both still shaped by the analytic situation (Aron, 2003; Greenberg, Ginot, Safran, & Riefolo, 2019). The patient, and countertransferentially (see below) often also the therapist, jointly and unconsciously "enact" a scenario from the patient's developmental history, rather than putting feelings, memories, and phantasies into words. Enactment both contravenes the fundamental analytic project – "where id was, there ego shall be" (Freud, 1923, p. 80) – replacing affect "discharge" with thoughtful consideration or mentalising, but also, if noticed and stopped in its tracks, ("pressing the pause button"; Bateman & Fonagy, 2019) provides vital *in vivo* evidence of the patient's dispositions and desires.

Strachey (1934) was the first to spell out the interpersonal implications of transference. For him, transference is essentially a *misperception* in which the analyst is seen in the distorted light of the superego – idealised, denigrated, as harshly punitive or judgemental. In everyday life, transferences create the vicious circles of neurosis, since others are recruited to behave (via projective identification; see Chapter 4) in ways that confirm the transferential preconceptions. The patient creates a world in which others are induced to *be* harsh, inconsistent, rejecting, and so forth, or even if not, they are perceived in that light. Analysts aim, through benign neutrality, spotting enactments as they happen (including their own part in them), and conveying this understanding in "mutative interpretations", to disconfirm the vicious circles. For Strachey, this leads to dynamic change based on the internalisation of a humanised, less harsh, rigid, or stereotyped superego.

Klein (1932) similarly saw transference as a manifestation of unconscious phantasy. Joseph (1985) equates transference with the "total analytic situation", but others feel that the term is in danger of becoming overinclusive. For Sandler, Holder, Kawenoka, Kennedy, and Neurath (1969),

the analyst is a real person, engaged in a specific task with the patient. Furthermore, following Strachey, some interactions with the analyst modify and disconfirm earlier responses to actual environmental failures, and therefore cannot be seen as transferential repetitions.

Greenacre (1954, 1968), like Freud and others, distinguished between a "basic transference" and the analytic transference proper. The basic transference of implicit trust reflects the early infant–mother relationship and allows the development of the therapeutic alliance, while the transference proper mirrors later conflictual aspects of development. The basic transference is a prerequisite for effective work within the conflictual transference relationship. For Brenner (1979), however, these are just different aspects of transference, and he rejects the concept of the therapeutic alliance altogether, pointing out that it is just as important to analyse the patient's "alliance" with the analyst as it is to analyse his resistances.

Example: The waving patient

A 28-year-old woman who had a rejecting and "workaholic" father continually formed short-lived sado-masochistic relationships with men. She reported that she had seen her analyst on his bike and had waved to him, but he had ignored her and failed to return her greeting. She began to berate him in the session, accusing him of being cruel and rejecting. The analyst had "genuinely" not seen her; he said that he could understand that she had felt rejected by him, but in reality he really had not seen her and so could not have acknowledged her, and if he had, he would have! The patient was unconvinced, but over subsequent sessions this episode opened up looking together at how past experience had sensitised her to such rejections, intentional or otherwise.

The analyst's reality-oriented statement attempted to discourage pathological distortions, as well as providing a way into interpreting the underlying unconscious fantasies. There were clear links to the past but, more importantly, the patient was unconsciously "shaping" the analyst to defensively invalidate her feelings, as part of a retaliatory cruel interaction. Meanwhile, the analyst searched himself to see whether there had been any contributing factors from himself or within his countertransference reactions (e.g., was she a bothersome younger sibling whose existence he wished to deny?) that had contributed to his "not seeing" her.

Analysts argue about whether it is "technically" correct to challenge a patient's perceptions in this way (Hamilton, 1993), or whether to focus solely on the meaning to the patient of everything that happens, relying on the

ongoing analytic relationship as the unspoken source of security. The developmental level at which the patient is operating will guide the analyst's strategy. For patients with borderline personality disorder, an honest, non-defensive analytic stance is the best way to counteract "epistemic mistrust" (Fonagy & Allison, 2014), while in less problematic patients a more direct confrontation, devoid of reassurance, may have greater mutative impact.

In sum, transference can be understood in a number of different ways:

- The process by which people transfer on to their analyst (and others) experiences, attitudes, and feelings derived from important figures and episodes earlier in life.
- The externalisation of internalised object relationships within the analytic process and within everyday relationships.
- All unconscious aspects of the analytic relationship, including non-verbal communications.
- As a "resistance". There may be a resistance to the development of the transference (e.g., attempting to keep therapy "business-like" and "practical") or the transference itself (e.g., getting stuck in transference love or hate), which then becomes the resistance to resolution of underlying conflicts.
- As a "probe" of relational reality (Slavin & Kriegman, 1992), for example, "Are you, or are you not, the all-loving caregiver I want so badly?"
- As a manifestation of latent meanings, stimulated by the real relationship with the analyst, but shaped and coloured by past experience.

Special forms of transference

Freud believed that one major difference between psychotic and neurotic patients was their incapacity to develop a transference relationship, but there is no doubt that he was wrong here. This is an example of how even masters can be blinded to reality by their theories. Because Freud theorised psychosis as a retreat into narcissism, by definition, interpersonal relationships – including transference – were impossible. Recent interest in severe personality disorders has also given rise to more detailed descriptions of transference phenomena in psychotic, borderline, and narcissistic disorders (see Chapter 10).

"Self-object" transferences

Self-psychology (see Chapter 2) pays particular attention to the development of the self. It sees the self in terms of three poles. The need to be recognised and seen as special crystallises at one pole; overarching ideals and values that epitomise one's stance in the world are at the second; and real talents

and skills cluster at the third. Each pole gives rise to "self-object needs", which in turn lead to differing self-object transferences.

If the patient feels passed-over and unrecognised, for example, a "defective mirroring" transference will arise out of the normal and necessary "grandiose-exhibitionistic" elements of the self. Just as the child who is collected from school is picked out by the parent from all the other children as special, eliciting a "gleam in his mother's eye", so the patient hopes upon hope that the analyst will see him as special. Without such mirroring in childhood, chronic low self-esteem is the rule. The child may escalate attempts to be perfect, or become a "show-off", continually craving approbation and admiration. Kohut (1984) argues that, like a good parent, the analyst should act as a mirror to these tentative searches for recognition and self-esteem, rather than puncturing them with premature interpretations.

Idealising transferences reflect the opposite pole: here, the patient sees the other as perfect; his homage to an "all-seeing" analyst attempts to vicariously strengthen his defective self-esteem. Some degree of idealisation and symbiosis is a normal part of an analytic relationship, but gods usually turn out to have feet of clay. Just as for the mirroring transference, Kohut (1977) argues that idealisation should be accepted; premature interpretation can lead to catastrophic disillusionment and feelings of unworthiness. Gradually, as analysis progresses and self-esteem strengthens, the defensive and unrealistic aspects of idealising transferences begin to fall away.

In the "twinship" self-object transference (Kohut, 1984), the individual feels unsure of his talents and abilities, and turns to a phantasied alter ego whose qualities are more securely grounded and who provides an externalised self-object to whom he can resort at times of loneliness and desolation. Here, too, more conventional interpretations would pick up on the patient's denial of the obvious differences between himself and the analyst, emphasising defences against dependency or feelings of inadequacy ("castratedness"; Barratt, 2019). Kohut argues, rather, that the analyst should wait patiently, accepting the patient's necessary narcissistic investment in the analytic relationship, and, again, that premature interpretation will only reinforce the patient's already defective sense of value and competence.

Psychotic transference

The term "psychotic transference" has been used in a variety of ways, ranging from situations in which the analyst feels out of touch with the patient, to attempts by the patient to force the analyst to think for him (Searles, 1963). The analytic literature tends to deploy the term "psychotic" rather loosely, for example, to describe a person's inability to conceive of others as having minds like their own, or to imagine that they could be held in mind by those who care for them. These would be "psychotic transferences" since the existence of the analyst as a thinking being is obliterated,

but such thought patterns would not be considered psychotic by psychiatrists.

A more appropriate use of the term "transference psychosis" concerns transient bizarre symptoms occurring in psychoanalytic sessions with patients who are faced with intolerable mental pain (Wallerstein, 1967). Such patients may have been taken on for psychoanalytic treatment without the severity of the underlying disturbance being recognised.

Example: The poisonous analyst

A depressed female patient in analysis was also seeing a psychiatrist. A trial of antidepressant medication had made little difference to her mood, and so the psychiatrist decided to try another drug. The patient had rapidly formed a strong bond to her analyst, whom she idealised as the person who was going to help her survive. She asked the analyst whether she should indeed try the new antidepressant. The analyst suggested that she should follow the advice of her psychiatrist; she took the drug but developed severe side effects. In the next session, she accused the analyst of poisoning her, and read out a written statement about trust and betrayal and demanded that he sign it. This delusional state led her to make a complaint to the analyst's professional body about the analyst's professional misconduct, which she withdrew the following day.

Transient psychotic symptoms such as this typically link to earlier experience. Here, the patient felt she had been abandoned by her mother to her violent, drunken father – just as she now felt that her analyst had abandoned her to the "poisoning" psychiatrist. Such individuals do not usually break down into a full-blown psychotic state, but are more likely to show further features of borderline personality disorder as treatment continues, including the development of an erotic or erotised transference.

Erotic transference

Psychoanalysis began with an erotic transference. Anna O unexpectedly developed such strong feelings, imbued with eroticism, towards Breuer that he broke off the treatment and "fled the house in a cold sweat" (Jones, 1953). He immediately went on a second honeymoon to Venice with this wife, and distanced himself from psychoanalysis. Freud (1915) later recognised the universality of affectionate and erotic feelings in the transference and saw them as valuable aspects of analysis, reflecting the patient's core pathology, which could be resolved within treatment. But as a

resistance, erotic transference can also be countertherapeutic, avoiding the need to face mental pain and to reflect on self-with-other. Transference love can be present in almost every therapeutic contact, whatever the gender mix of the analytic dyad (Bolognini, 1994); if recognised by the patient it may arouse feelings of shame and embarrassment. Joseph (1987) and Steiner (1982) suggest that the exciting and gratifying aspects of the interplay between the patient and analyst arise as a defence against the ambivalence of the depressive position, or the fragmentation of the paranoid–schizoid position. *Eroticising* a relationship can also be thought of as a way of forcing the object to respond when, on the basis of childhood neglect, one despairs of a caring reaction. Whatever angle is espoused, erotic, loving, and affectionate strivings can propel an analysis forward if treated sensitively within a sufficiently rigorous setting and overall approach.

By contrast, so-called *erotised* transference (Blum, 1973; Rappaport, 1956) may threaten the very existence of the analysis (Etchegoyen, 1991). Erotised transference differs from erotic transference and transference love in that the demand for sexual gratification is extreme and not experienced by the patient as being unrealistic, and is a subcategory of psychotic transference. Persistence of erotised transference may lead to a breakdown in treatment or, disastrously, acting out on the part of the analyst (Gabbard, 2013). Blum (1973) reported that patients developing an erotised transference showed a number of common features in their history: sexual seduction in childhood, inadequate parental protection, and family tolerance of incestuous/homosexual behaviour. The erotised transference seems therefore to represent a repetition and perhaps also a desperate attempt to rework the earlier sexual traumata. Erotised transference inevitably causes severe countertransference and technical problems for the analyst. Suffice it to say here that erotised transference requires all the skill, knowledge, and ethical integrity of the analyst if treatment is to succeed: as Person (1985, p. 163) puts it (and Breuer discovered to his cost), it is "both goldmine and minefield". We turn now to countertransference, which similarly offers both treasurous and treacherous opportunities.

Countertransference

> No psychoanalyst goes further than his own complexes and internal resistances permit. (Freud, 1910, p. 116)

The term "countertransference" has undergone a number of radical changes in meaning since it was introduced by Freud (1910, p. 139), where he defined "Gegenübertragung" as "result of the patient's influence on the [analyst's] unconscious feelings". Initially, like transference, it was regarded as a hindrance or danger to analysis (Freud, 1912), representing the need for further analysis for analysts, especially were they to respond in kind to a patient's

erotic transference. Today, countertransference is a central part of analytic theory and technique (Loewenthal, 2018). The term is seen primarily as referring to *those thoughts and feelings experienced by the analyst that are relevant to the patient's internal world* and which may be used by the analyst to understand the meaning of the patient's communications. This "patient-derived countertransference" contrasts with the earlier notion of an impeding "analyst-derived countertransference" (Langs, 1976).

Recent research (Holmes, 2014; Holmes, 2018) based on the Freud–Jung letters suggests that Freud was privately intrigued by the positive aspects of countertransference. However, keen that the public image of psychoanalysts should be untarnished, he framed their role as experts, standing apart from the hurly-burly of the session, invested with authority, and arbiters of what was normal or pathological. Countertransference in this model referred to the analyst's complexes, which might interfere with accurate listening to unconscious processes. There was no public acknowledgement by Freud other than that countertransference might impede the quasi-surgical detachment he advocated, with no mention that it might be useful in understanding unconscious communications.

Ferenczi (1922) was the first to challenge this view. Via his "active techniques", he advocated much greater involvement between analyst and patient. However, he continued to see countertransference in terms of the analyst's own difficulties in which they might, for example, narcissistically encourage their patients' flattery or dependency. This view continued until after Freud's death, until the rise of the object relations school in Britain and the interpersonal tradition (Sullivan, 1953) in the United States stimulated closer examination of what countertransference might entail. The Balints (Balint, 1952; Balint & Balint, 1939) (Michael Balint was Ferenczi's analysand) suggested widening the scope of the countertransference concept, but it fell to Winnicott (1949), Heimann (1950), and Little (1951) to produce the most cogent case for a revision.

This major conceptual shift caused reverberations throughout the psychoanalytic movement. Some embraced the new approach, while the old guard hung on to the more restricted view of countertransference as unconscious interferences in the analyst's capacity to understand and interpret appropriately (Fliess, 1953; Reich, 1951). For the interpersonalists, such as Sullivan, this sea change was a confirmation of their view that the relationship was the crucial factor in therapy, and represented the final blow to what they felt was the authoritarian and rigid stance of hide-bound US psychoanalysis. For British analysts, it was the start of a creative and fertile debate.

Paula Heimann's (1950) paper remains a cornerstone of contemporary thinking about countertransference. The essential element of the new idea was that the analyst's own feelings, attitudes, and associations to the patient's communications and behaviour were helpful in understanding the

unconscious processes occurring in the patient, even though the analyst may at first not be fully conscious of them, and come to recognise them only through supervision together with careful self-scrutiny. Heimann (1950, p. 82) went further: "all the feelings the analyst experiences towards his patient" are countertransference, and it is "the patient's creation, it is part of the patient's personality". Inevitably, this further fuelled the controversy, as it became allied to other Kleinian challenges to Freudian orthodoxy such as questioning the centrality of the Oedipus complex. Klein herself was wary of this revisionist view of countertransference and expressed caution about its link with projective identification; nevertheless, her colleagues pushed on with the idea that the two concepts were inextricably linked, almost to the point that they were indistinguishable.

Countertransference, empathy, and projective identification

In projective identification (see Chapter 4), the patient projects "disavowed" aspects of himself into the analyst, who becomes unconsciously identified with them and may begin to feel or behave in accordance with them. The first aspect of this process is clearly allied to transference, while the second can be correlated with countertransference given its interactional ambiance. Racker (1953, 1957, 1968) explicitly linked the two aspects, distinguishing between what he called "complementary" and "concordant" countertransferences.

Complementary countertransferences are emotions that arise out of the patient's treatment of the analyst as an object of one of his earlier relationships, and are closely linked to projective identification. Complementary countertransference is somewhat akin to the pre-Heimann model in that analysts, based on their own unconscious and unacknowledged needs and developmental residues, enact a role that complements the patient's projections. Seen more generally, these can be seen as manifestations of the analyst–patient interactional dynamic. Thus, a dependent patient will evoke an over-protective analyst, or patients who view their objects as rejecting and hostile will evoke these emotions in their analyst. Getting stuck in these complementary binds may result in impasse or failure to progress. But from a post-Heimann perspective, to the extent that they are identified and mutually examined they become helpful grist to the analytic mill.

Concordant countertransferences are empathic responses based on the analyst's resonances with the patient, and are not solely a result of projective identification. Concordant countertransferences link with affective attunement, empathy, mirroring, and a sense that certain aspects of all relationships are based on emotional identifications that are not solely projections. Similarly, Money-Kyrle's (1956) account of "normal countertransference", and Bion's (1962) description of communicative projective identification, represent positive connotations of countertransference.

Stern's (1985) observations of "affective attunement" between mother and baby, and, by extension, between patient and analyst, offer an evidence-based way of thinking about the transference–countertransference matrix. The empathic mother is able to mirror, identify with, differentiate, regulate, and name her child's affects. In this "borrowed brain" (Holmes, 2020) model, the child, via "projective identification", evokes feelings in the caregiver, which are reciprocally represented in such a way that the child begins to "see" his emotions and re-introject them.

The neo-Kleinian model, starting from Bion (1967), sees this as non-pathological, communicative projective identification in which the mother uses her "alpha function" to process the infant's dissociated "beta elements". If development goes well, this oft-repeated process builds up a store of self-knowledge and self-regulatory capacity in the growing child. There is debate about whether affective attunement equates to empathy (Hoffman, 1978). Some authors argue that affective attunement takes place outside consciousness, while empathy involves cognitive processes. Affective attunement is a more immediate emotional response, much as one may shout "Aaaargh!" and suck one's finger when someone else hits theirs with a hammer.

Empathy and affective attunement in a psychoanalytic universe are seen as representing "normal" as opposed to pathological projective identification, as first delineated by Bion (1962). Projective identification was originally thought of as a pathological process, based on an externalisation and actualisation of an internal object relationship in which the analyst takes on a particular role that is thrust upon him – that is, complementary countertransference. By contrast, in empathy there is no such enforced role, and the analyst uses a transient identificatory processes to tap into the patient's underlying affect. This is dependent on the analyst's capacity for "regression in the service of the ego" (Kris, 1952, 1956) while maintaining a hold on his ability to think and reflect. This debate is far from academic in that there is robust evidence that affect regulation in therapy is associated with good outcomes (Rice & Hoffman, 2014).

Sandler (1993) uses the term "primary identification" to encompass empathy, seeing it as similar to preconscious mirroring. Thus, if the analyst has a spontaneous emotional reaction to a patient's actions or behaviour – such as feeling tearful, vicariously angry, or horrified – this should not be seen as projective identification but as exemplifying primary identification. Only if such identifications stimulate unresolved unconscious themes within the analyst will conflict arise, leading to defensiveness and blind spots.

Bion's (1962) model of container and contained suggests that there is a "normal countertransference" in which the transference–countertransference dynamic moves along constructively between patient and analyst. In Bion's model, feelings are communicated to the other, digested, and returned to the projector in a modified and acceptable form. Only when this process is

disrupted by failures of understanding on the part of the analyst and/or by projective processes so violent or psychotic that they cannot be contained within the analytic frame does pathological projective identification emerge. Even these "failures" have therapeutic potential. The patient may escalate the projections, communicating feelings he himself experienced in relation to important others in his past (see also Chapter 4). It is often only after reacting inappropriately in some way – that is, getting in touch with their countertransference feelings and/or enactments – that analysts realise they have allowed themselves to be pulled into such a position, and can begin to unravel and identify with the patient's traumas.

Sandler (1976) describes this process as "role responsiveness" on the part of the analyst, in which the patient attempts to bring about in reality an unconscious wishful phantasy by "casting" the analyst in a particular part in his inner drama, while he himself occupies a reciprocal role. For all this to be therapeutically useful, analysts are presented with a difficult balancing act, needing to be both involved and detached, listening to the patient, reflecting on their own feelings, playing their allocated part and at the same time extricating themselves from such a role. The clinical emphasis is on the patient's affects that are projected, and the extent to which the analyst can "metabolise" or "digest" the feelings they engender without enacting them.

Example: Further thoughts on the waving patient

After accepting that he had not seen his patient waving at him, the analyst began to wonder if there was indeed a blind spot in himself, if he was "not seeing" something in the analytic material, or if he was failing to address some aspect of his patient. Looking back, the analyst realised that he had been making an uncharacteristically large number of empathic remarks in recent sessions. For example, when his patient had been talking about her father's rejections, rather than focusing on her anger, he had underlined how hurt she had felt and how she must have wished for his love. At the same time, he recalled that he had felt increasingly sleepy during sessions. Perhaps, colluding with the patient's fears, he was shutting his eyes in order not to see something in her? Based on this countertransference response, the analyst interpreted that perhaps the patient was wanting to be seen, but something inside her was asleep, unable to be roused. The patient's own tender and loving feelings were concealed beneath her sado-masochistic attacks. Furthermore, the analyst realised that his own tender feelings for his patient were also covered over, lost in his rather conventional empathic remarks. He had been blind to them. These feelings were in turn related to his own anxieties about developing positive feelings towards his female patient: better not to notice her

while he was cycling along than unearth possible erotic transference and countertransferences. This circuitous route was needed before bringing it all back to her unrequited need for a loving father.

Pick (1985) develops Bion's idea of the containing function of the analyst, emphasising the need for the analyst to be open and receptive to the patient's unconscious communications. The analyst will have her own primitive functions within her personality, which may collude with the patient's projections through identification – for example, to be a caring, loving, all-curing mother – and until "disidentification" takes place the projections will not be analysable or even recognised. However, from a post-Heimann perspective, this formulation also incorporates the classical conception of countertransference, and Reich (1951) put forward a similar idea using the term "defensive countertransference", emphasising the need for the analyst to be alert to these identificatory aspects of herself. Only when "minus K" becomes "K" can patients be helped to face previously unacceptable aspects of themselves, and take back their projections – paralleling a similar process in the analyst. This view emphasises the symmetrical, or concordant, aspects in the analyst's personality in relation to the patient, and hence the equality, albeit "lop-sided" (Barratt, 2017), within the relationship.

A further influence on thinking about countertransference emerged as analysts turned their attention to working with borderline and psychotic patients. Winnicott (1949) coined the term "objective hate" to describe a natural response in the analyst to patients' sometimes outrageous or provocative behaviour. He argued that this did not arise from unresolved conflicts in the analyst, but was a normal commonsense reaction. This assertion, despite somewhat patient-blaming, was important in that it removed the pejorative, guilt-inducing aspect of countertransference prevalent at the time. Building on this insight, Kernberg (1984), in his work with patients with borderline and other severe personality disorders, saw countertransference as a multifaceted process in which difficult emotional feelings are inevitably aroused in the analyst.

Definitions of countertransference

- Affective resonance and empathy (Stern and Winnicott)
- The results of projective identification (Klein, Bion, Steiner, etc.)
- Part of the bipersonal or intersubjective field (Sullivan and Langs)
- The analyst's response, conscious or unconscious, to the patient's transference (Heimann and Sandler)
- The analyst's transference response to the patient, that is, the patient representing important people from the analyst's past (Freud)

- The analyst's blind spots or resistances (Freud and Sandler)
- All reactions of the analyst to his patient (Joseph).

This list summarises the various meanings associated with the concept of countertransference, and is yet another illustration of Sandler's (1983) notion of conceptual "elasticity" in psychoanalysis. The different definitions of countertransference depend on how narrow or broad a boundary is drawn around the term.

Summary and conclusions

The focus in contemporary psychoanalysis is mainly on countertransference as a means by which the patient's mental state is communicated to the analyst. This communication happens in a number of different ways, not all of which are, strictly speaking, "countertransferential". First, there are the analyst's capacities for affective resonance, empathy, trial identification, and primary identification. Second, the analyst may have an immediate reaction to something about the patient – such as feeling threatened – arising more from the analyst's internal world and not a result of the patient's unconscious intent. Third, feelings in the analyst may arise through the process of projective identification, in which there is an unconscious push for the analyst and the patient towards enactment of earlier unprocessed or verbalised feelings or trauma.

The projective identificatory aspects of countertransference have received the most attention from Kleinian analysts. Affective resonance, empathic responses, and primary and trial identificatory processes have gained the interest of the ego psychologists and other developmentally oriented analysts. Knowing how and when to use countertransference – turning intellectual understanding into affectively relevant interpretation, direct emotional reactions into understanding, and identification and sympathy into empathic comprehension – are the quintessential analytic skills.

Overall, the controversy about the definition of countertransference has abated. Although himself somewhat forgotten or even discredited, Langs's (1978) concept of the *bipersonal field* firmly located countertransference as an interactional phenomenon and not solely within the realm of either the patient or the analyst. The bipersonal field is an idea borrowed from physics, which has been creatively developed by the Bion-influenced Italian analyst Ferro (2006; Ferro & Civitarese, 2015). The boundaries of the field are defined by the analytic setting, to which the patient and analyst both contribute from their own psychological worlds. If we regard the analytic dyad as two mutually influencing psychological systems, then the intermingling of transference and countertransference becomes a subtle interplay of these systems within a highly charged affective milieu – a four-way matrix between the patient's and the analyst's conscious and unconscious systems. Money-Kyrle (1956) predicted

such developments by suggesting that the emotional task of the analyst is to distinguish his own unconscious phantasies from those of his patient. Failure to do so leads to "positive countertransference", which takes the form of placating the patient and giving reassurance, or "negative countertransference", in which the patient is subtly attacked via "interpretations".

Baranger (1993) sees the bipersonal field itself as akin to Bion's (1952) idea of a group mind. From a neuroscience perspective, Holmes (2020) describes this as a "duet for one" in which the patient "borrows" the analyst's mind to explore his own. All told, modern countertransference implies an active participation by the psychic processes of the analyst as well as the patient, overthrows the notion of the analyst as a neutral mirror, and moves the analytic encounter from the objective toward the subjective. Transference and countertransference have become complementary processes that blend to form a unique pattern in each therapy, with its own personal history and culture, and co-created by the patient and analyst.

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Chapter 6

Dreams, symbols, and the psychoanalytic imagination

> Psychical reality is a particular form of existence not to be confused with material reality. (Freud, 1900, p. 620)

From a psychoanalytic perspective, psychological health depends on finding a balance between adaptation and exploration, attachment and separation, maturation and regression, the inner and outer worlds. We now turn to the uncoupling of inner from outer reality, which forms the essence of dreams and imaginative play. As the demands of adaptation are relaxed, so a clearer picture of the inner world emerges – a window, a *via regia* or "royal road" (Freud, 1900) into the unconscious.

Freud considered *The Interpretation of Dreams* his finest as well as his most personal work, laying the foundations for the entire edifice of psychoanalysis. "Insight such as this falls to one's lot but once in a lifetime", he claimed, explaining how writing it was "a portion of my own self-analysis" stimulated by "my reaction to my father's death – that is to say, to the most important event, the most poignant loss, of a man's life" (Freud, 1900, 1925a).

That statement in itself locates its author – historically, ethnically, and by gender. In the century since Freud first started to try to understand his dreams, much has changed in our neuroscientific understanding of dreams and psychoanalysis itself. In the course of this chapter we shall trace some of those changes. We begin with an exposition of Freud's novel model of dream formation and their meanings.

Freud's model

Freud started from two fundamental questions. What is the *function* of dreaming – why do we dream at all? – and how do we account for the strangeness of dreams, their *bizarreness*? As we shall see, his answers to both these questions are, in the light of subsequent knowledge, at least partly wrong. We should also note his wish to link dreams with abnormal mental

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functioning: "it is my intention to make use of my present elucidation of dreams as a preliminary step towards solving the more difficult problem of the psychology of the neuroses" (Freud, 1900, p. 104).

When, on the night of 24 July 1895, Freud dreamed his famous "specimen" or "Irma" dream, his self-analysis led him to believe that he had solved the problem of the purpose of dreaming, and with this discovery he had fulfilled his personal dream of fame: "a dream is the fulfilment of a wish" (Freud, 1900, p. 122).

Example: Freud's "specimen" dream

"Irma" was a patient, Emma Eckstein (Roazen, 1979; Schur, 1966), about whom Freud was worried. The day before the dream he had met a colleague, "Otto" (Dr Oscar Rie), who had seen her recently. Freud asked how she was; "Better, but not quite well", came the reply. In the dream, Freud meets her at a party; he sees that she is unwell and worries that he has missed an organic illness. Freud and three other doctors then examine her; she opens her mouth and they find large white patches on what look like turbinate (i.e., nasal) bones. Freud decides that she *is* unwell and that this must be due to an injection of "trimethylamin" from a dirty syringe given to her by Otto. He sees the formula for trimethylamin in front of him printed in heavy type.

In his analysis of the dream, Freud connects this with the sexual theories of Fleiss, who also believed that there was a link between the nose and the genitals, and who had in fact operated on "Irma's" nose.

In Freud's model, freed from the constraints of reality and under the sway of the pleasure principle, and in response to some current preoccupation, or *day's residue,* a person's deepest feelings and desires are activated. By blaming his friends and colleagues, the Irma dream acquitted Freud of responsibility for the deterioration in Irma's condition about which he felt so guilty. But these desires, often expressions of infantile sexuality (curiously, Freud hardly touches on these aspects – four men examining a female "cavity", one of them a "dirty squirter"; Erikson, 1954), are disturbing to the conscious mind, whose awareness of the constraints and prohibitions of reality, although relaxed in sleep, is not wholly in abeyance. The disturbing wishes threaten peacefully sleeping consciousness, which wants no more than to remain in slumber. Wishes, therefore, are cleverly disguised in the compromise created by the *dream-work*. In this modified form, their "cathexis" (i.e., psychic energy) is discharged without at the same time awakening the sleeper. Thus, "the dream is the guardian of sleep" (Freud, 1900, p. 234). Like a secret code in times of war, a hidden message has been

smuggled through hostile enemy lines (the *censor*), without suspicions being aroused by its *manifest* content. The bizarreness of dreams is a consequence of this scrambling of the original, or *latent*, content of the dream. Unravelling or decoding dreams reveals our phantasies of what we "want" but, in reality, is oedipally unattainable.

Interpreting dreams, a primary tool of analysis, means reversing the process of disguise, undoing the dream-work to reveal the original wish beneath it. Just as the hysterical patient was to have the underlying impulse behind her symptom uncovered, so that she could own her desire and so no longer be in thrall to it, interpreting dreams entails understanding how dreaming turns "thoughts previously constructed on rational lines" (Freud, 1900, p. 597) into puzzling imagery and juxtapositions. Dream analysis, as Freud conceived it, is a triumph of the rational over the irrational.

Freud identified a number of ways in which the original dream thoughts are modified on their journey from the unconscious to the manifest narratable dream. In *condensation*, different elements are combined or fused into a single image, so that the explication or unpacking of such an image is invariably longer and more complex than the dream itself. To take an unusual but amusing example, Rycroft (1979) describes a man named Ernest, whose dream consisted of the single word *Frank.* This dreamer had been involved in financial deceit, and needed to remind himself of the importance of being honest (i.e., "frank").

Example: Puns and amalgamations

Another example of condensation occurred in the dream of a highly ambitious and narcissistic man whose mother had been both seductive and inaccessible. He dreamed that he *met a friend on a train whom he had not seen for a long time. When he asked him what he was doing these days, the man replied that he was appearing in a television programme called "Knockers"*. The "man" was a condensation of two successful colleagues who, in contrast to his own faltering career, the patient imagined had access to the girls and the glory that he so craved. The condensed double meaning of "knockers" contained both his envious tendency to "knock" worldly success, and a denigratory "macho" word for the breasts he enviously imagined the colleagues enjoying.

Displacement resembles the prestidigitation of the magician: the censor's attention is distracted by a shift of emphasis, so that what is important in the dream may appear in the manifest content to be insignificant, and vice versa. To unravel displacements, therapists need to be alert to the multiple meanings, or *polysemy*, of language. For example, a young man with anxiety

about making love to his girlfriend was initially puzzled by a dream in which he was *swimming in deep water, doing the breast-stroke*, until he suddenly realised in the dream an allusion to his sexual fears.

A central concept in Freud's exposition of dream decoding is that of *trains of thought* as a bridge between the conscious and unconscious minds. Based on *free association* (see Chapter 8), the dreamer explores his responses to the dream's ingredients, following the *fundamental rule* in which no image or thought is suppressed, however trivial, embarrassing, or irrelevant it may seem. With the help of free association, the dreamer gains access to his *dream thoughts*, which have, "under pressure of the dream-work ... [been] broken into fragments and jammed together – almost like pack-ice" (Freud, 1900, p. 312). In this process of *condensation*, the logical connections between ideas become obliterated, and thoughts are presented in visual rather than verbal form. These processes Freud calls *representation* or *dramatisation.*

In the second and subsequent editions of *The Interpretation of Dreams*, under the influence of his disciple Stekel (whom he subsequently repudiated), Freud included a discussion of *symbolisation* in dreams. The "Freudian symbol" has become a cliché, but Freud believed that the fundamental biological themes of life – birth, gender, parenthood, sibling relationships, sex, death – are represented in dreams by universal symbols reflecting humankind's archaic psychic heritage. This idea was later greatly elaborated by Jung, in his notion of "archetypes". Freud was critical of the dream-book, "this means that", approach to dream unravelling. Freud insisted on the personal meaning of the dream elements, illuminated primarily by free association. For example, a woman who had had a miscarriage dreamed of *a small cutting from a plant that was pulled up by its roots and died*. From the outside, the metaphor is self-evident, but to the dreamer it was a shocking reminder of how she still grieved for her unborn child. This example illustrates how displacement is a special case of the general phenomenon of symbolisation. Another example warns against facile readings of symbols in dreams:

Example: A Freudian fish

A woman dreamed that she was *holding a large live fish that wriggled frighteningly within her grasp*. "A fish", she said, "that's a Freudian symbol – it must be a penis". But, when asked for her associations, she remembered that her mother was a *Piscean*, and a fanatical believer in astrology, and the dream led to a discussion of her fear of her mother's disapproval of psychoanalysis.

The final phase of the dream-work was called by Freud *secondary elaboration* or *secondary revision.* This refers to the way in which, while recalling the dream, the subject automatically edits and cleans up the text, giving it greater coherence and intelligibility. With his mistrust of the manifest content, Freud saw this as a further obfuscation of dreams' true meanings. He pointed out that if dreamers are asked to repeat their dreams, elements that have been left out in the first telling emerge, often with great significance. For example, a woman whose mother had had a postpartum depression after a stillbirth, when the patient was 3 years old, recalled on second telling a dream in which "*I was in a large house, empty and rather gloomy...oh, I've just remembered, my mother was there, crying and turned away from me*".

Although Freud remained loyal to his original conceptions about dreaming – and, by the 1930s, bemoaned their relative neglect by the new generations of analysts (Freud, 1932) – he recognised one outstanding exception to the wish-fulfilment hypothesis. These are *post-traumatic dreams*, in which the patient repeatedly dreams of an undisguised painful or terrifying event. Freud saw this as attempting to gain mastery over psychic stimuli that threaten to overwhelm the individual (Freud, 1920) – in Bion's terms, to "contain the uncontainable" (Garland, 2002). Drawing on his unpublished "Project" (Freud, 1895), he viewed emotional trauma as "energy unbound". The function of the dream here is not as a guardian of sleep and wish fulfilment, but to "bind" psychic energy, as a necessary precursor to the processes of repression. Anzieu (1993) argues that, rather than this being an exception to the wish-fulfilment rule, all dreams can be seen as based on the micro-"traumata" that comprise the day's residue in need of psychic processing – a view that is, as we shall see, consistent with contemporary neuroscientific models of dreaming.

Post-Freudian psychoanalytic views of dreaming

Each of the different psychoanalytic schools has developed its own slant on dreams. Jung (1916; Freud & Jung, 1974) was the first to dissent from Freud, although his views represent more a shift of emphasis than a radical departure. He saw dreams as openly rather than clandestinely expressive of the inner world: "a symbol does not disguise, it reveals", and thus paid more attention to the manifest content of the dream than Freud recommended. In line with his idea of the repressed bisexual "shadow" self, he saw dreaming as driven by the "*compensation principle*" in which dreams "try to re-establish equilibrium by restoring the images and emotions that express the state of the unconscious". In this move from drive-theory to *Self* he saw dreams as peopled by aspects of the psyche that the dreamer has neglected or suppressed, an idea that was to re-emerge in a different guise with the development of self-psychology. For Jung, the dream as a manifestation of

the unconscious is not so much "irrational" as representing a complementary rationality. As Rorty (1989) puts it, "it feeds us our best lines".

The Interpretation of Dreams contains the first comprehensive account of Freud's "topographical" theory of the mind (see Chapter 2). Freud never fully revised his ideas on dreaming in the light of his more mature "structural" model (Freud, 1923). However, towards the end of his life he ascribed a synthetic *conflict-solving role* to the dreaming ego, reconciling the demands of the id and superego (Freud, 1940), more akin to the revelatory Jungian model. Ego psychologists have developed this, again by emphasising the importance of the dream's manifest content, seeing the dream as attempting to recover repressed, neglected, or avoided affective experience (Brenner, 1993). Erikson (1954), in a classic paper, re-analysed the "Irma" dream and showed how the manifest content reveals an ego struggling with all the doubts and conflicts that beset Freud, especially his wish both to become recognised as a leader and yet to remain separate from the antisemitic Viennese medical establishment. The "Irma" dream is undoubtedly a "dream from above" (Freud, 1925b) – that is, one stimulated by current conflicts rather than originating "from below", based primarily on infantile conflicts. This is consistent with historical research suggesting that Freud was preoccupied with anxieties about the rather dubious nasal operation performed on "Irma" by Fleiss, whom he was about to drop as a mentor (Loewenstein, 1969).

An important breakthrough in psychoanalytic dream theory was Lewin's (1955) notion of the *dream screen*. The advent of film in the early decades of the 20th century prompted Lewin to ask: what is the "screen" on which the highly visual quality of the dream-drama is projected? His answer was that it is the maternal breast, flattened and invisible, except perhaps in "blank" dreams. As Pontalis (1993, p. 111) puts it: "to Freud, the dream was a displaced maternal body...he committed incest with the body of his dream".

Lewin's insight led object-relations analysts to think of the dream itself as an "object", and that the way patients relate, and relate to, their dreams is as significant as the dream-content itself. Thus, the patient who overwhelms his analyst with long, tortuous, and muddling dreams may be conveying an experience of confusion and psychic entrapment; or he may "evacuate" his dreams into the passive analyst as a way of ridding himself of hostile and frightening feelings. An obsessional recording of dreams and detailed recounting of them in the session may reflect patients' sense of an inner world that is only just alive, so that each creative product has to be preserved and revered. There may be a fear of losing what is good inside, or a contrast between a dramatic and vivid dream life, and depression and emotional poverty in patients' waking hours. "We know too well that patients learn to exploit our interest in dreams by telling us in profuse nocturnal productions what they should struggle and learn to tell us in straight words" (Erikson,

1954, p. 346). The "use" of a dream may be masturbatory rather than relational.

The idea of the dream screen creates a context for dream analysis: the dreamer and his relationship to the analyst matter as much as the dream itself. The patient who told her analyst of a dream in which there was a "*perfectly harmonious moment of peace in which you lay beside me and put your arm around me, in a non-sexual way*" felt anxious and tense throughout most of her sessions and had intense waking phantasies of sexual involvement with him. This "bliss" dream represented a wish for a moment of maternal reverie, sadly absent in her childhood; a reproach to the analyst for failing to provide what she wanted so badly in her waking life; and a message to herself about how she used sex mainly as a means to "pre-sexual" maternal merging.

Once the dream is grasped in a context of relationships, it is possible to see dreams as *sleeping thoughts*: "dreams are nothing other than a particular *form* of thinking" (Freud, 1900, p. 506). As Brenner (1993) puts it, "we are never fully awake *or* asleep". Bollas (2011) has shown how we unconsciously assemble around us objects, interests, and occupations in our waking life that reflect our core unconscious "pre-occupations" (or "destiny"), just as the dream is furnished with the contents of our inner world. Drawing on Winnicott, he advocates how, based on countertransference, the analyst must try to capture and put into words this ceaseless quotidian activity of phantasy: "the analyst dreams his patient" (Bollas, 1992), an idea also developed extensively by Ogden (2016).

Continuing Jung's idea of the dream as a manifestation of the inner self, self-psychology approaches the dream as an existential statement, with an equilibrating function based on the "need to maintain the organisation of experience" (Stolorow, Brandchaft, & Atwood, 1987). Kohut (1983) writes of "self-state dreams", in which the manifest content is an expression of the patient's current *modus vivendi*. The young man who dreamed that he was *clinging to his mother, while telling her he was "dead"*, was expressing his lack of inner aliveness, his pervasive anxious attachment, and perhaps also accusing her of intrusively "robbing" him of his liveliness. It is a useful rule of thumb to assume that all the "characters" in a dream represent parts of the patient's self, and that aggression, sexuality, submission, anxiety, persecution, retribution, and so forth, may be split off from the waking self, but embodied and so potentially recoverable through the analysis of their appearance in dreams.

Dreams and modern neuroscience

There has been a gradual shift within psychoanalysis away from Freud's original twin preoccupations with the function of dreaming as wish fulfilment, and the pre-eminence of the latent content. The sharp distinction

between latent and manifest content has blurred, and the emphasis is more on the overall meaning of dreams and their communicative role in therapy, seeing their content and form as aspects of the total analytic relationship. These changes are consistent with neurophysiological ideas about dreaming. The discovery by Aserinsky and Kleitman (1953) of rapid eye movement (REM) associated with dreaming stimulated a burst of sleep research. An important finding was that REM appears to be integral to mental health – subjects deprived of REM deteriorate into a confused state much more quickly than those deprived of non-REM sleep. This means that Freud's discovery about dreaming is now reversed: we do not dream to sleep, but sleep to dream (Rycroft, 1979). However, not all REM is associated with dreaming, and not all dreaming is associated with REM. Dreaming appears to be a response to arousal stimuli, of which REM is the most common but not the only source (e.g., epilepsy sufferers dream during nocturnal seizures). Solms (1997) plausibly claims that Freud's idea that a dream is an attempt to maintain sleep in the face of arousal remains valid.

The dominant neurophysiological paradigm in dream research is Hobson's (1977)*activation-synthesis hypothesis*. Possibly based on the sexual cycle of arousal, consummation, and latency, Freud assumed, teleologically, that the ultimate "purpose" of mental activity was the discharge of accumulated psychophysiological "energy" and return to a presumed state of quiescence. He saw dreaming as a form of discharge by stealth.

The current view is that the main "purpose" of dreaming is informational rather than energetic. With external stimulation (but not interoceptions from the heart, gut, genitals, etc.) in abeyance, the brainstem starts to spontaneously generate neural activity in the cerebral cortex, via the default mode network (Buckner, Andrews-Hanna, & Schacter, 2008). Recently activated pathways (the "day's residue") remain in need of "housework" – that is, discarding the irrelevant, and the consolidation of novel experiences into memories. Presented with an array of disparate memories and experiences, the brain, as a virtual reality generator (Hobson, Hong, & Friston, 2014; Hopkins, 2016), assembles them into meaningful patterns – coherent, if seemingly bizarre, stories. The strangeness of dreams results from the lack of an external confirmatory or disconfirmatory input, and the absence of modulatory neural activity.

In Freud's model, meaning is *subtracted* from the latent dream-thoughts to evade the censor. Activation-synthesis sees meaning as *added* to a potentially incoherent array of images. The dreaming brain is struggling not to disguise coherent but unacceptable thoughts, but to make sense of an array of chaotic imagery. The "housekeeping" function leads to the consolidation of salient day's experiences into the "generative models" with which we make sense of the world (Hobson & Friston, 2012). These models are assimilated into the primal relational experiences in childhood. By pointing to

these fundamental themes, the dream remains a "royal road" to the dreamer's guiding assumptions, preconceptions, wishes, fears, and hopes.

Dream theory can be thought of as a blank screen on which each school of psychoanalysis projects its own version of the psychoanalytic story. From a relational perspective, dream interpretation will inevitably reflect not just the wishes and preoccupations of the dreamer, but those of the analyst as well. The Heimann model of countertransference (see Chapter 5) points to the difference between analysts using their unconscious responses to the patient's dreams to further understanding, and their imposition of their own neurotic or theory-driven preconceptions. Freud's insistence on breaking the dream into its component fragments, and being guided by the patient's free associations, guards against such analytic intrusions: "dream interpretation...without reference to a dreamer's associations, would...remain a piece of unscientific virtuosity of very doubtful value" (Freud, 1925b, p. 128).

Dreams and the language of the unconscious

The movement in dream theory from drive-theory-derived mechanisms to meaning-based approaches implies the need for analysts to learn to understand and speak in dream-*language*. Ella Sharpe (1988), in her classic *Dream Analysis*, systematically compares the language of dreams with poetic diction, as did her analysand Charles Rycroft (1985), who noted Darwin's reference to Richter's aphorism, "the dream is an involuntary kind of poetry". Sharpe sees Freud's "condensation" as an example of *metaphor*, in which similarities are found in the apparently dissimilar – as in the use of shots of trains entering tunnels or firework displays to represent sex in Hollywood films at a time when the censor insisted that a man's foot remain in contact with the floor during love scenes. "Displacement" uses both metonymy, in which comparisons are evoked by linguistic proximity (as per the "*breast-stroke*" example earlier in this chapter, which evokes thoughts of both swimming and sex), and synecdoche, in which the part stands for the whole (*fish* standing for the zodiac, the zodiac standing for mother). Punning and onomatopoeia are also integral to dream language: *knockers* in the earlier example; Segal's (1991) patient who dreamed of soldiers marching *eight abreast* – "ate a breast"; names such as *Bournemouth*, *Master Bates*, *Chester*, and *Prixford*.

Poetry, like dreams, is *polysemic* (i.e., contains many possible meanings, all of which are mutually compatible) and prefers the particular to the general. My love is not just universal love, but one that's like a rose, a "red, red" one, that's "newly sprung in June". The devil is in the detail. When analysing dreams it is always important to "drill down", asking the patient to elaborate with more detail, and with the question "What else…?", one dream thought will always lead on to another. As Sharpe (1988, p. 39) put it:

"the bridges of thought are crossed and recrossed by *names*, and names have manifold mutations", reminding us of the multiple connections and pathways of the nervous system that underlie memory, and how memory storage is spread throughout the brain rather than localised.

Lacan's (1997; Fink, 2011) famous aphorism "the unconscious is structured like a language" is based on the fundamental linguistic distinction between the "signified", that is, that which is represented – for example, the furry feline domestic quadruped that has just walked into the room – and the "signifier", that is, that which "represents" it, in this case the word "cat". In Lacan's view, dream representation is always in the form of Freud's "rebus", that is, a picturegram in which the realm of the "real" or signified – primordial unstructured experience – is encoded in the symbolism of the "signifier". Dream narratives remind us that what we call "reality" has always been worked on by the unconscious, transforming raw day's residue experience into meanings unique to the dreamer's developmental history. Language captures experience, but in ways constrained by both the polysemy of words and the speaker's attachment history, which shapes their conversational style (Talia, Muzi, Lingiardi, & Taubner, 2020). Lacan's view is not unlike Bion's notion of "alpha elements", which emerge from the interaction between "beta elements" and a transforming mind, whether in the reverie of the maternal breast or its analogue, the dreamer and his dream. An attachment perspective reminds us that language is *communication*, bringing the dialogic aspect of speech into focus. From this perspective, dreaming can be thought of as dreamers' efforts to hold conversations with themselves about the links between their daily lives and their fundamental concerns.

Khan (1993), who was much influenced by Winnicott, describes the "good dream" in which conflict is metabolised and worked on without the intervention of the meddlesome conscious mind, and Sharpe (1988) discusses the dreams of successful analysands in which, she claims, there is evidence of reduced feelings of shame, and greater integration of past and present, body and mind. To paraphrase Winnicott (see later in this chapter), analysis could be described as "learning to dream" (Bollas, 2011; Cooper, 2006; Ogden, 2016). Although dream analysis perhaps no longer holds the same pride of place as it did for the analytic pioneers, dreams remain central to analytic work. A dream is an indispensable reference point, a marker of the state of the patient's psyche. Dreams cut through intellectualising and, however confusing, have a freshness and unquestionable validity that verbal speculation about feelings or emotional tendencies may lack (Rycroft, 1979). Via the day's residue, dreams bring the important issues of the patient's day into the analytic arena. Awareness of dreams puts patients in touch with the impersonality of their creative self, potentially decreasing narcissism and increasing self-esteem and self-mastery. It often brings the transference into clear focus. A recurrent dream can encapsulate the central dramas and

dilemmas of a patient's life in a vivid form, while subtle alterations in the emphasis of the dream may mark progress in treatment.

Example: Claustro-agoraphobia in a recurrent dream

A middle-aged teacher who had grown up on a working-class estate in Scotland, and who veered unhappily between homosexual and heterosexual relationships, repeatedly dreamed of *being by the door of his house and trying to leave, but unable to because he was being held by the testicles*. His father had been a violent drunkard, and his mother had turned to him, an only child, for comfort and protection. Early in treatment, he saw the dream as representing the way in which his mother "had him by the balls"; as treatment progressed he began to experience her – and the analyst's – holding as protective and nurturing.

The basic techniques of analytic dream interpretation remain essentially the same since Freud's first recommendations (Freud, 1912): break the dream into its component parts; pay particular attention to the patient's free associations; ask the patient to repeat the dream as a way of capturing more of the dream-thoughts; do not let the analyst's assumptions and theories impose themselves on the creativity of the dream; do not ever expect fully to understand the dream, which retains an impenetrable and unanalysable "navel" (Freud, 1900). More recent approaches (Fonagy, Kächele, Leuzinger-Bohleber, & Taylor, 2012; Ogden, 2017) see the dream in the total context of the session and the analytic relationship; pay attention to the form and manner of the dream's telling as well as its matter; see the working through of traumatic experience as a central issue in dreaming; and give equal status to the manifest and the latent content.

The dream continues to offer itself as both a mystery and a treasure-house of meaning. "What do you think about while you are asleep?", we ask our patients – or, with Jung (1974), say "Now let's get back to your dream. What does the *dream* say?".

Symbolism and the creative imagination

We have already mentioned the tension between Freud's wish to understand dreams to illuminate the neuroses, while at the same time wanting to provide a general psychological account of the workings of the unconscious. Given that REM sleep and dreaming are universal among humans, and indeed many other species, and that Freud viewed the dream as a sort of neurosis,

and the psychotic is often described as a dreamer awake, does this mean that we are all mad, or at least partially so?

Freud's devoted follower Ernest Jones (1948) argued that there is a phenomenon of *true symbolism* by which otherwise inaccessible ideas, feelings, and wishes subject to "primal repression" gain access to the conscious mind. As Freud (1916, p. 161) put it:

> the number of things which are represented symbolically in dreams is not great. The human body as a whole, parents, children, brothers and sisters, birth, death, nakedness – and one thing more.

The "one thing more", following Freud's coy trope, is sex itself. Jones, and probably Freud, believed that due to "primal repression" some aspects of life, normal or not, could *only* be "represented" indirectly via symbols and never experienced directly and in full force, thus putting repression and the potential for neurosis at the heart of dreaming, creativity, and cultural life generally. This idea has been revived in contemporary neuropsychoanalysis via the concept of "mentalised interoception", referring to the ways in which "bottom-up" somatic sensations, whether from the gut, heart, or genitals, are met by "top-down" prefrontal cortex language-based "generative models" (Holmes & Nolte, 2019). Helping patients to attend to, name, and contextualise bodily sensations is intrinsic to analytic practice via free association, especially with people with alexithymia, who find it difficult both to experience their feelings and to put them into words (Duquette & Ainley, 2019; Fotopoulou & Tsakiris, 2017).

A contrasting model is implicit in Rycroft's (1968, 1979, 1985) distinction between primary and secondary processes (see Chapter 2). For him, dreaming is primary-process thinking in its purest form; to equate primary processes with pathology and secondary processes with psychic health is misguided, since normal mental life requires a balance between the two:

> Visual, symbolic, non-discursive mental activity is just simply the way in which we think while asleep ... there is no reason to suppose that symbolism is essentially a device by which dreamers deceive and obfuscate themselves, even though it may on occasion be used as such. (Rycroft, 1968, p. 51)

Like Lacan, Rycroft views psychoanalysis as primarily a linguistic discipline, but one that is biologically based, in that it is concerned with the fundamental issues that affect us all – as in Freud's formulation, love, sex, procreation, survival, rivalry, and death. Symbolism is central to the expression of the "few things" we have strong feelings about, not because of repression but simply because *symbolism is the mode of representation of affective*

experience. The clinical implications of this are two-fold. First, analysis values symbolic expressions, whether in dreams, jokes, slips of the tongue, puns (as in the "punconscious"), or squiggle-game drawings (Winnicott, 1971a), highlighting the patient's feelings in their most vivid form.

Second, dream symbolism frequently, if not always, contains implicit reference to the body. A patient who dreamed of a *wooded valley swarming with soldiers* turned out, when analysed with free association, to be thinking about his hostile sexual relationships with women. The wooded valley represented the vulva, the soldiers his sperm, while the dream depicts a phenomenon with much wider implications – sperm that is hostile and attacking, rather than loving and tender – than the merely physical. Sharpe (1988) suggests that the "dead metaphors" of a patient's speech often contain cryptic reference to bodily experience – the patient who keeps wandering off the point may have had difficulties in feeding, the man who is always beating about the bush suffering from fears about heterosexual lovemaking, and so on.

Matte-Blanco (1975, 1988) contrasts "*bivalent logic*", that is, secondary-process thinking, with "the principle of *symmetry*", which tends to obliterate distinctions, and is equivalent to Freud's primary processes. In symmetrisation – a form of over-generalisation – all members of a set are taken as identical, creating feeling categories such as "motherliness" or "breast-ness". The bizarreness of dreams would be a manifestation of this collapse of distinctions between psychic and external reality. He postulates a gradient from bivalent to symmetrical, with "*bi-logical*", which has features of both, in the middle. Emotions tend to be particularly subject to symmetrical thinking: when falling in love we enter "indivisible mode" in which our love-object is the "most beautiful person in the world". In psychological illness, the balance between symmetrical and bivalent logic breaks down. For example, if part is taken for whole, then an angry father may mean an "angry penis", and this may underlie a symptom such as impotence in which a man may experience his penis as potentially damaging. This viewpoint can be related to the procedures of cognitive therapy (Beck, 1976) in which bivalent logic is used to challenge a neurotic individual's tendency to make unwarranted generalisations (e.g., "If I don't succeed in this task, I am a failure"), "catastrophise" problems, and fail to make significant distinctions.

Segal, from a Kleinian perspective, revived Freud and Jones's attempt to differentiate healthy from pathological use of symbolism in her concept of the *symbolic equation*. This refers to an aspect of psychotic thinking in which the sufferer equates (symmetrises) the symbol with the thing symbolised, the signifier with the signified. Segal famously contrasted two patients, both violinists, one of whom justified his refusal to perform in public by exclaiming angrily "Do you expect me to masturbate in public?", while the other had dreams suggesting a link between performance and masturbation,

but was able in reality to play satisfactorily. For Segal, symbolic equation is associated with the paranoid–schizoid position and the excessive use of projective identification, as in the violinist unable to perform. In her view, to symbolise, we need to be able to see ourselves and our objects as separate: "only what can be adequately mourned can be adequately symbolised" (Hinshelwood, 2018; Quinodoz, 2011; Segal, 1986). This perhaps raises the question of what is meant by "adequately", but the distinction is clinically useful:

> Every man marries his mother...the wife may symbolise and contain some aspects of the mother, or she may feel to *be* the mother, in which case the marriage carries all the prohibitions and conflicts of the relation to the mother. (Segal, 1991, p. 47)

Segal, like Rycroft, sees symbolisation as a "core primary activity" of the psyche, as opposed to Freud and Jones's view of symbols as merely one mode of evading the censor. In this neo-Kleinan perspective, symbolisation enables transformation. In Bion's quasi-scientific terms, symbols are "unsaturated" – the analogy is with chemicals that are free to form bonds with other elements – and so available for "realisations". Linguistically, symbols are polysemic – they can have many meanings, and so form psychoanalytic bridges whereby patients can move from one set of meanings to another, with the freedom and innovation that implies.

The inability to use symbols can take the form either of Segal's symbolic equation in which reality is so "saturated" with phantasy that the two cannot be differentiated, or the opposite, in which the capacity to phantasise is so impaired that affects cannot be put into words, as in alexithymia (Bird & Viding, 2014; Nemiah, 1978). Both present particular technical problems in analysis: the symbolic equator is unable to maintain the necessary state of metaphor and "virtuality" in relation to his analyst, tending to become overdependent, sexualised, or psychotically angry in ways that are inaccessible to reflection and mentalising. In alexithymia, patients are expected to talk about feelings, but it is the very impossibility of this, and therefore the presence of psychosomatic disorder, that brings them into therapy. Neither of these impediments is insuperable or invariant, and modified psychoanalytic techniques, such as the use of role-play or art materials, may help to circumvent them.

The recovery of creativity – which is closely related to the capacity to symbolise – can be a critical moment within an analysis, increasing the patient's sense of self-worth and generativity. The discovery of an impersonal "non-ego" creative force marks a movement away from narcissism and the use of projective identification to more mature object relations.

Example: Breaching the self-sufficient circle of narcissism

A man in his late twenties entered analysis complaining of depression after a failed marriage. He felt dull and useless, was envious and competitive with women, and was failing to progress in his career. His father had died when he was 8 years old and he saw his sisters as having been close to his mother, who, in the absence of his father, had both revered and controlled him. In the first year of analysis, his dreams were all in monochrome, as they had been for as long as he could remember. Then he dreamed of *a snake curled round on itself with a tampon in its mouth. The tampon was removed and the snake began to bleed.* He then realised that the dream was in colour, as were his dreams subsequently. Following this episode, he felt a surge of creative energy and began to paint furiously. The dream seemed to symbolise an escape from the circle of femininity within which he had grown up, offering a chance to mourn his dead father and to reach for his own, more mature, masculinity.

Play

Psychoanalytic ideas about play are particularly associated with the work of Donald Winnicott (1965, 1971a). Winnicott was analysed by Joan Riviere, who was in turn greatly influenced by Melanie Klein. For Klein, the child's use of play materials is seen, dream-like, as an expression of unconscious communication, and can be "interpreted", just as a dream might be analysed in therapy with adults. Kleinian analysis with adults, especially in its purest form, approaches everything – actions, words, affective expression – that the patient brings to the session as unconscious material, to be woven into an interpretation, in the same way that the elements of a dream are treated as manifestations of desire, trauma, and defence.

Ego psychologists were troubled by the notion of dreams as expressions of disguised and disruptive desire rather than manifestations of a synthesising and self-actualising self (Erikson, 1954, 1959). Similarly, Winnicott resisted conceiving play exclusively as a manifestation of unconscious repressed thought. He emphasised the creative, synthetic aspect of play, and put it into an interpersonal real-life object-relations context, while at the same time retaining the idea that it emerged from the depths of the psyche.

Example: "Give sorrow words"

A girl of 5 years was referred for therapy because of delay in speaking. With pipe-cleaner figures and a doll's house, she silently demonstrated how her parents slept apart and how her father came into her bed and abused her. At each stage, the therapist described in words what was happening – "now the daddy comes downstairs…", "now he is getting into bed...". Haltingly, the girl repeated the therapist's words. The play reflected her inner world, but could be expressed verbally only in the context of a responsive and attuned therapist.

Winnicott's notion of *transitional space* tries to reconcile the enigma of how external reality (including, as in the case of the 5-year-old girl, traumatic horror) instantiates itself in the inner world.

> in the play area the child gathers objects or phenomena from external reality and uses these in the service of...inner or personal reality. (Winnicott, 1971b, p. 51)

In Winnicott's (1965) model, what makes trauma "traumatic" is the victim's passivity and helplessness in the face of impingements over which she has no control. Therapy helps because, via transference and projective identification, elements of the original trauma will inevitably be repeated in the analytic situation. Thus, the person who has been neglected as a child (neglect is as harmful as sexual or physical abuse, or even more so; Institute of Medicine and National Research Council, 2014) may experience analytic breaks or weekend separations as cruel abandonments, triggering maladaptive self-soothing. Analysis brings these "into the area of omnipotence" – the patient's sense that she is responsible for her pain can be examined and challenged, her rage expressed, and her suffering co-regulated. Casement (1985, 2019) uses these Winnicottian ideas in his prototypical case, in which the patient's hand was deformed due to being badly burned when she was 2 years old. Only when the trauma was reawakened *in vivo* in the analytic relationship could it be transcended: when the sufferer felt that she had some control over what happened, and survived. Casement argues against reassurance – the patient's request that she hold the analyst's hand – in that it short-circuits this process of re-experiencing the trauma in the service of recovery, akin to a controlled explosion of an otherwise lethal bomb.

Winnicott sees the origins of play in the earliest caregiver–infant relationship where, by her "primary maternal preoccupation" and intense involvement with the baby, the mother fosters in the baby an illusion of *healthy omnipotence*. She anticipates her baby's wishes, which enables the

child to feel he has brought about or created the feeding breast, the playful reciprocating smile, the nurturing arms. Later, there will be gradual processes of disillusionment, triggering healthy protest, tolerated by the secure mother, and leading to healthy rupture/repair cycles.

In this schema, this opens up an intermediate or *transitional* zone between phantasy and reality, a virtual space that includes soft toys and security blankets and the imaginative play they represent. Later still, the transitional phenomena encompass cultural phenomena such as the arts, science, and sport (Holmes, 2001). The "soft space" of the transitional zone is precarious and liable to be threatened – either from within by instinctual needs (e.g., hunger must be satisfied before play can occur) or from outside by "*impingements*" (another Winnicottian term) such as parental seductiveness or control, leading to false self, inauthenticity, and failures of real creativity.

Meares (2016) specifically links the problems of self found in borderline personality disorder (see Chapter 10) with a deficit in playfulness in childhood, arising from neglectful or abusive parenting, and describes the gradual acquisition of playful self-absorbed inner dialogue as successful analysis progresses.

To summarise, according to Winnicott (1971a) psychotherapy is "learning to play", a view not unlike Bion's (1963) abstract notion of the transformation of beta elements into alpha elements by the analyst's "thinking breast". For Ogden (2008), Bollas (2011), and Ferro (Ferro & Civitarese, 2015), the aim of analysis is to tap into the waking dreaming that characterises our everyday choices, tribulations, and joys. As treatment progresses, the analytic session becomes more and more a "play space", in which, based on the analyst's attunement, "give" or "play" come to the fore in the analytic relationship, thus enabling the patient to recover his lost creativity and selfhood.

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Part II

Practice

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Chapter 7

The assessment interview

> He that has eyes to see and ears to hear may convince himself that no mortal may keep a secret. If his lips are silent, he chatters with his fingertips... (Freud, 1905a, p. 76).

The psychoanalytic assessment interview is important not just because it represents a critical moment of choice for both patient and analyst, but because within the harmonies and discords, the false starts and emerging themes of the initial encounter, are to be found in microcosm much of what is to come in the course of treatment.

The word "assessment" is derived from the Latin *assidere*, to sit beside, but also contains overtones of legal assizes, and the assessment of taxes, in which an individual's assets are reckoned and weighed in the balance. There are thus two strands in the assessment interview: an empathic attempt by the analyst to grasp the nature of the patient's predicament, and a more distanced effort to sum up his strengths and weaknesses. Analysts will ask themselves how "analysable" is this person, while the patient will try to decide what benefit may flow from investment in this treatment.

The term "analysable" can mean "understandable" or "treatable", which are far from the same thing (Tyson & Sandler, 1971). For many patients, an assessment interview may help to clarify and illuminate their difficulties, even if the final decision is against psychoanalysis as the best treatment for this person. The purpose of the interview is to provide sufficient relevant information, and a sample experience of working therapeutically, to enable both patient and analyst to decide how to proceed. The patient will get a snapshot of what analysis might be like. Analysts, who may or may not take the patient on, have to be engaged enough for an affectively meaningful therapeutic encounter to happen, while at the same time remaining sufficiently objective for their findings to be generalised to other analysts or therapists.

These dual functions – objective and subjective, a view for the analyst of the patient, and for the patient of the analyst – are reflected in the

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psychoanalytic literature on assessment. Some writers firmly couch themselves in the language of medicine, listing the "indications" and "contra-indications" for therapy (Malan, 1979), the characteristics of "analysability" (Coltart, 1986), diagnostic and prognostic features (Kernberg, 1982), and the developmental level of the patient's personality organisation.

There is limited experimental knowledge of pre-treatment characteristics that predict response to treatment in psychoanalysis or, indeed, in any psychotherapy (Orlinsky, Grawe, & Parks, 1994). Based on common sense and experience, in looking for positive signs of good engagement with psychoanalysis, clinicians emphasise a number of main themes, which we shall explore in the course of this chapter:

1. *Motivation.* To what extent will the applicant be able and willing to sacrifice the time, money (if in private practice), and emotional energy needed for successful treatment?
2. *Psychological mindedness* – that is, showing curiosity about how the mind works, including one's own mind, and a capacity for self-scrutiny.
3. *Ego strength* and ability to form constructive relationships and to withstand and profit from the painful revelations and regressions entailed in psychoanalytic therapy.
4. The ways in which potential patients *respond to the interpersonal aspects of the assessment interview* itself, including to "trial interpretations" (Hinshelwood, 1991).
5. The analyst's *countertransference reactions* (Carvalho, 2016), which, whether positive, negative, or neutral, will have to be evaluated in the light of the patient's developmental history.

The analyst will then bring these strands together in a *formulation,* which summarises the central themes of the patient's current and past life situation, especially as manifest transferentially and countertransferentially in the interview.

Given the increasing complexity of psychological presentations, contemporary psychoanalysis has moved from a quasi-medical and inflexible set of "indications" to an emphasis on "suitability" (Tyson & Sandler, 1971) and to the modifications of psychoanalytic technique that entails (Kernberg, 1984). This places the responsibility on the assessor to decide how psychoanalytic treatment can be modified to help a patient, rather than to how a patient needs to change to "fit" psychoanalytic treatment. Indeed, borderline personality was first described in the context of a group of patients who did not respond to standard psychoanalytic technique (Stern, 1938). Modifications were developed, taking into account the specific problems of the disorder, which now are manualised as transference-focused psychotherapy (Yeomans, Clarkin, & Kernberg, 2002).

Psychosis is usually considered a contraindication for psychoanalytic intervention due to the absence of evidence for positive effects (Gunderson, 1984; Gunderson, Carpenter, & Strauss, 1975), but some psychotic patients may be able to work psychoanalytically with a suitable analyst (Jackson & Williams, 1994; Lucas, 2009; Rosenfeld, 1952) (see also Chapter 10), and psychoanalytically informed interventions may benefit people with psychotic symptoms when they are treated in the community using a needs-adapted approach (Martindale, 2017).

Conducting the assessment interview

In the light of the above considerations, the analyst approaches the interview with two potentially mutually incompatible aims – to garner relevant factual information and, at the same time, to create an atmosphere in which unconscious material can emerge. If direct questioning is eschewed altogether, then important data will be lost; if it dominates, then all the analyst may get is unelaborated answers to his questions. Many analytic institutes and psychotherapy departments try to overcome this problem by sending the patient a detailed questionnaire to be completed and returned before the interview takes place. This can form a useful basis for discussion, although patients can find it intimidating to be asked to reveal intimate details in an impersonal form, and it also has the disadvantage of depriving the interviewer of hearing *how* the patient tells their story – where they put emphasis, the tone of voice they use to describe events and relationships, significant omissions, their overall narrative style (Holmes, 2020; Talia, Muzi, Lingiardi, & Taubner, 2020) – all of which are vital sources of psychodynamic information.

Freud liked to compare analytic treatment with a game of chess in which there is an almost infinite number of possible moves, but where phases can usefully be divided into opening strategies, middle game, and end game. Comparably, in opening the assessment interview the analyst will probably proceed in a fairly standard way with each patient; the middle game will include attempts at interpretation and observation of their affective impact; and, towards the end, there will be a gathering up of the threads and coming to a decision about treatment.

Introduction and preliminaries

From the point of view of the unconscious, psychoanalysis starts from the moment, or indeed well before, the analyst and patient meet (Thomä & Kächele, 1987).

Example: The imposter

The analyst noticed a momentary look of surprise and hesitation on his patient's face when he went to the waiting room to collect him for the first time. In the interview, the young man turned out to be extremely over-sensitive and vigilant, and to have apparently suffered greatly at the hands of a harsh stepfather. He spoke of how he thought constantly and in an idealised way about his own father, whom he had not seen for many years. When the analyst mentioned his manner in the waiting room, the patient said that he had been expecting someone fat, short, and bald, with a beard and a foreign accent, and had imagined for a moment that the person who had come for him was an imposter. They were able usefully to link this transferential percept with his suspicious feelings about the rejecting stepfather who had been "imposed" upon him, and his longing for a "real" father of his own.

Each interviewer will have his own particular style and set of opening gambits. These will be modified to help each individual patient enter into the spirit of the analytic interview. In our view, it is important to behave with ordinary professional "off the couch" courtesy in greeting a new patient, including introducing oneself and giving one's name clearly. This extends even to responding conventionally to apparently trivial (but often significant) remarks that the patient, driven by anxiety, may make between the waiting area and the consulting room, while at the same time noting and, if considered appropriate, returning to them in the course of the interview (Coltart, 1993).

Others argue, however, that the assessor should always be as neutral and as silent as possible to arouse the patient's maximum anxiety and so gain access to areas of possible disturbance that would otherwise be missed in the more conventional atmosphere of a friendly "bedside manner" (Milton, 1997). The effectiveness of this approach will depend on the level of a patient's psychological disturbance. A patient with borderline functioning may become so anxious about a neutral face that this factitious ultra-neutrality will precipitate rapid destabilisation, making the assessment gruelling or impossible. Generally, it is safer to take the more facilitative approach at the beginning of the first meeting and only gradually become more reticent. Some analytic assessments take more than one session, and the high-risk approach may at times be useful in a second meeting to stimulate focus on unconscious material and so give the patient a taste of what treatment itself might be like.

Example: Difficulty parking

Say, for example, the patient mentions as he sits down that he had difficulty finding a parking space. The interviewer might (a) agree that parking has become a problem in the area (a supportive and urbane intervention), (b) interpret this along the lines of anxiety about whether there is going to be enough therapeutic space for him to "park" his difficulties (a precipitate introduction to the realm of the unconscious significance of everyday talk), (c) speculate about sibling rivalry and the patient's competitiveness (an interpretive suggestion aiming to generate imagination, creativity, and perhaps playfulness), or (d) say nothing, to avoid being drawn into a collusive complaint about the crowded state of the roads, rather than focusing on the patient's internal world (perhaps the most unnerving intervention!).

Opening moves

Menninger (1958) argues that as the patient has implicitly asked a question in coming for help, and is likely to be in a state of considerable anxiety, it is up to the analyst to respond by getting the first session rolling. The initiative will be handed back to the patient once analysis proper has begun. In general, the analyst will need to be much more active and encouraging in an assessment interview than in subsequent treatment, although a balance still has to be struck between sufficient warmth to enable the patient to unburden, but not so much that the necessary ambiguity that enhances transference is lost.

A useful opening question can be to enquire what the patient was thinking about as he was coming to the session or waiting to be collected. This signals, from the start, that the analyst is interested in the patient's inner world, and allows the patient to express anxiety in an accepting atmosphere. From then on there are no firm guidelines, and the analyst needs an "elastic interview technique" (Balint & Balint, 1971), which covers all the important areas without prejudging the order in which they are tackled.

The presenting problem and its antecedents

A clear understanding of why the patient has come for help at this particular moment is essential (Malan, 1979), and this part of the interview should never be skimped, however keen the patient may be to move away from the present to talk about childhood trauma, for example. As we shall see below, dynamic understanding of the presenting problem is one of the three legs on which the tripod of the psychodynamic formulation rests. A statement along

the lines of "I've heard a bit about you from your doctor, but it would be best if you could start by telling me in your own words what has brought you for help" will set the session in motion. If the problem has been present for many years, as it often has, then it is essential to clarify the question: "Why now?". For example, the fact that a husband is attending because his wife has issued an ultimatum that she will leave him unless he gets help will need to emerge if the patient's motivation for change is to be gauged adequately.

The interview plan

The analyst will, by the end of the interview, want to have covered the main features of the patient's current circumstances, family background, detailed developmental history including psychosexual history, early memories, history of major losses and traumata (including specific enquiries about sexual abuse), dream life, main areas of interest and aptitude and values, and sources of both stress and support. Psychiatric aspects, including history of hospital admissions, use of psychotropic drugs, suicide attempts, substance abuse, and "mental state" features such as depressive, obsessional, and psychotic phenomena, will also need to have been covered either in the interview in the case of medical psychotherapists, or by the referrer if the analyst is not medically or psychiatrically qualified. It may not be possible to cover such an exhaustive list in the course of a freely flowing first interview. Winnicott (1965) described psychoanalysis as an "extended form of history-taking", and much detail will emerge once treatment proper has begun. If the interviewer is unsure of the patient's suitability, based on doubts about how psychiatrically ill the patient may be, a second assessment interview may be needed. As we shall see, thorough assessment pays dividends and may forestall later difficulties.

The interview as a psychodynamic "probe"

A central purpose of the assessment interview is to act as a stimulus to the patient's unconscious. The therapeutic setting and the person and style of the analyst will in themselves arouse anxiety and hence, if handled with the right balance between support and distance, evoke unconscious reactions. The interviewer may want to tap into phantasy life by asking directly about the patient's earliest memories, what he thinks about as he is falling asleep, what his daydreams and secret ambitions are ("What would you really like to happen?") and, of course, dreams proper ("What do you think about while you are asleep?"). The aim is to create an atmosphere in which innermost fears and phantasies can be explored, and to judge the patient's reactions to the analyst's efforts to foster "associative freedom" (Spence, Dahl, & Jones, 1993).

Therapeutic interventions: the "trial interpretation"

Although attentive listening is the key to any psychotherapeutic encounter, the analyst will be far from silent or passive. His interventions will start by questioning, mostly in the form of open questions ("Tell me a bit about your family"), and move on to clarifications ("You mentioned almost in passing that your parents split up when you were 11 years old; can you tell me about your emotional reactions when that happened?"). The interviewer will always be looking for vivid detail rather than vague sweeping statements (e.g., patient: "My mum was just a normal mum"; analyst: "Can you give some examples so that we can get a clearer picture of what that felt like for you?"), and will note the likely defensive aspect of such vagueness.

At some point, the analyst will want to probe the patient's analytic potential by appropriately weighted challenge, confrontation, and/or trial interpretation. These are a cluster of interventions based on a psychodynamic hypothesis, offered so that the patient is asked to think about himself in a different way. The tone and timing of such interventions is crucial, and they should be attempted only once a reasonable therapeutic alliance has been established. If premature, they will glance off with little impact; if delivered without finesse, they will evoke a defensive reaction and decrease rapport; if too intellectual in content, they will fail to elicit an affective response. To be effective, they should be fairly brief and simple:

- "Do you think it is possible you arrived late for your appointment today because you had mixed feelings about coming?" (confrontation)
- "Maybe there is a connection between your depression now and the fact that your daughter is now exactly the same age that you were when your parents split up?"
- "I wonder if behind your depression there isn't a lot of anger, similar to what you felt when your mother suddenly had a baby and you were no longer the only object of her affection?" (interpretation)
- "Perhaps you see me as rather like your stepfather, a rather remote and uncaring figure, out to find fault with you" (transference interpretation).

Note that these interventions are best given in a tentative style, allowing the patient to disagree, modify, amplify, or use them as a springboard for further elaboration – a process Malan (1979) calls "leapfrogging".

Options, decision, contract

On the basis of the middle phase of the interview, and particularly the response to interventions, the analyst will be looking for three key "process" features that are positively correlated with good outcomes: the ability to form a good rapport or working alliance; to work with interpretations; and

to respond affectively within the session – to allow feelings of fear, sadness, or anger to surface.

At the end of the interview, the analyst will summarise the ground that has been covered and, with the patient's help, reflect on their encounter to come to some kind of conclusion: "We're nearing the end of the session, and I think we should spend a few minutes deciding where we go from here"; "Do you think that working in this way might be helpful to you?", "Is this the sort of thing you were expecting?". When psychoanalysis was the only form of psychotherapy available, the decision was fairly simple – to treat or not to treat. Today, psychoanalysis is just one of a range of therapeutic options, and only a small percentage of those assessed will end up in five-times-a-week analysis. Coltart (1987), the doyenne of the assessment interview in the United Kingdom in the 1980s, reported that only 5% of those who consulted her chose full psychoanalysis. Most analysts consider it good practice to acquaint the patient with the scope of therapeutic possibilities, discussing their various pros and cons. The analyst should then state clearly what he considers, at this moment, to be the best investment, given the patient's personal and financial resources and in the light of what is realistically feasible. If the assessor plans to take the patient on themselves there will also need to be, at this point, a discussion about practicalities: fees, how many times a week they will meet, some idea of the possible length of analysis, holiday arrangements, and so on.

In general, a period of reflection following an assessment interview is no bad thing: both parties may agree not to decide immediately. The patient may want to think it over, and to discuss the decision with his family; the analyst and patient may come to the conclusion that they need to meet again for a more extended period of assessment or "trial of therapy" (Peterson, 2012); or the assessor, if he is not in a position to treat the patient himself, may need to explore possible vacancies with colleagues.

The psychodynamic formulation

As the interview progresses, or if the analyst already knows something about the patient even before their meeting, hypotheses and ideas about the nature of the patient's difficulties will be coming together in the analyst's mind. Ever since Strachey's (1934) seminal paper on interpretation, psychodynamic understanding has been seen in terms of a tripartite formulation, bringing together in relational terms (a) the current difficulty, (b) the transferential situation, and (c) the infantile or childhood constellation of conflict or deficit. This is Malan's (1979) "Triangle of Person" – intimate other, analyst, and parent(s) (see Chapter 8).

Example: The man who could do everything

John, a vigorous man in his mid-forties, came for help because, for the first time in his life, and entirely unexpectedly, he felt he could not cope with his work. From his early twenties, he had established his own business, a successful building and development firm; he was well respected in his community, happily married with successful children, and had a range of sporting interests. Suddenly, he felt tired and irritable, apathetic yet at the same time worried about every little detail, and unable to sleep properly. He felt like walking away from everything and had transient suicidal ideas. Antidepressants had helped only a little. The immediate precipitant of this depression had been a minor car accident, in which he had been run into from behind when stationary, while his son, who was driving, was waiting to turn right. He had been jolted, but there was no further physical trauma.

When asked about his parents, he said rather dismissively that his mother had died the year before, but that this was of no significance because he disliked her, and in any case she lived in the United States and was a "naturalised American citizen". He was an only child; it turned out that his parents had split up when he was a baby, and he had been brought up by his uncle and aunt, who had no children of their own. They had doted on him and he was the apple of everyone's eye both at school and at home: "The only cloud on the horizon was when my mother or father came to visit; they just stirred things up".

As the interview progressed, the analyst began to have an almost physical sensation of grappling with this powerful man, as though they were wrestling. He felt that it was very important that he should be firm and assertive. For example, John was clearly nonplussed at finding himself as a potential psychoanalytic patient, because this was very much not the image he had of himself as self-sufficient, strong, and well-balanced, and he would normally not dream of having any truck with (in his word) "psycho-business".

Feeling for the "point of maximum pain" (Hinshelwood, 1991) the analyst saw how, as a child, John had defended himself against the unhappiness of his parents' separation, and the helplessness of his position, by an omnipotent sense of his own strength and independence. The combination of the accident and his mother's death had exposed him to these potentially dangerous feelings of vulnerability once more. He dealt with them in his characteristic style by trying to fight his way out of trouble, but now he was battling with himself.

Guided by his countertransference, the analyst saw John's shame about asking for help, and their struggle as being rather like a little

boy saying to his uncle (whom he perceived as good, but weak) "You're not my real father". This triumphal oedipal self-aggrandisement was slipping away from him. The analyst said: "Throughout your life it has been very important to you to feel powerful and strong, to be your own self-protector. As a little boy you had no father to turn to for strength. Your sadness about your missing mother could not be expressed. It is as though the accident has exposed some weak and vulnerable son-father part of yourself that you have always kept well hidden. It seems somehow shameful to you to have to consult someone like me, whom you would normally rather despise, in the same way you didn't think much of your uncle". The patient seemed to relax at this point and responded, while shedding tears for the first time in the interview, by speaking of his sexual and metaphorical impotence, and saying how ashamed he felt of himself, and especially of his angry outbursts. This led to an agreement about the need for a trial of analysis.

The analyst's comment was based on the "Triangle of Person", bringing together past relationship (absent father/"weak" uncle), current difficulty (his son's "violence" and its impact on him as a father), and the transference (wrestling with the analyst). It similarly illustrates the "Triangle of Defence" (Malan, 1979), comprising anxiety, defence, and "hidden impulse". John's anxiety was his fear of losing his strength and vitality; his defence was to work, to fight, to impose his will by brute force – strategies tinged with narcissism and omnipotence; his hidden impulse was the wish to be held and protected and nurtured by someone he could trust.

Reaching a dynamic level is not simply a matter of applying a formula, such as Malan's, which then automatically yields up the appropriate interpretation. The assessor has to struggle not just with the patient's resistance but also with his own. Here is one analytic therapist's attempt to capture something of this:

> ...often I encounter an almost physical sensation of unwillingness within myself when faced with the need to move the patient from a fairly comfortable level of history-taking into the realm of the unconscious. Why disturb the doctor–patient equilibrium? Why run the risk of upsetting or even antagonising the patient? And, above all, how best to do it? More often than not, the key lies in the countertransference, often in the form of an affective response. If I feel a pricking behind the eyes, the patient is probably in a state of grief; if I feel irritated, he is sitting on a powder-keg of rage; if I am bored and detached, perhaps he was never really focused on as a child. I must use whatever sensations or

> phantasies are aroused in me by the patient's presence and his story to shape my interventions, and so whisk him away, however momentarily, from his static defended state into the fluidity of feelings. (Holmes, 1995, p. 26)

Diagnostic schemes in psychoanalysis

The polyglot nature of contemporary psychoanalysis makes it difficult to produce a standardised diagnostic schema. But, as one aim of psychoanalytic treatment is to integrate personality function to support effective and constructive relationships and to induce greater resilience to life stress, attempts have been made to assess personality function in a way that is more clinically relevant to psychoanalysts than current psychiatric classifications are. Westen and Shedler (2007) developed the Shedler-Westen Assessment Procedure (SWAP) to measure personality pathology and specifically emphasise clinical psychoanalytic process in that the ratings take into account *how* the patient tells something, the *way* the patient relates to the clinician, and the countertransferential reactions evoked in the clinician. This generates a clinically relevant formulation that outlines a person's dynamic conflict–defence pattern, which can then be used as a focus in treatment.

Kernberg (1975) describes levels of personality organisation, relying on dynamic ideas of primitive or pre-oedipal function and mature or oedipal function, defining neurotic, borderline, and psychotic structures, which are thought to reflect increasing severity and decreasing responsiveness to psychoanalytic treatment (Lowyck, Luyten, Verhaest, Vandeneede, & Vermote, 2013; McWilliams, 2011). His "structural interview" elicits identity integration, defences, quality of object relations and self–other representations, capacity for self-observation, conflicts, and typical transference and countertransference processes (Horz-Sagstetter et al., 2018).

The Psychodynamic Diagnostic Manual (PDM) (Lingiardi & McWilliams, 2017) and the Operationalized Psychodynamic Diagnosis (OPD) (OPD Task-Force, 2008) share a common aim of informing treatment planning for psychoanalysis and psychoanalytic psychotherapy. Both identify an individual's personality patterns, elicit detail of mental functioning in terms of conflict, defences, self-regulation, and self-reflection, and define symptom patterns. Research using these standardised assessment methods remains sparse, and clinicians are unlikely to use them in everyday practice as they are cumbersome. Nevertheless, they represent the gradual move in psychoanalysis from over-reliance on clinical knowledge to a more empirical attitude to practice while remaining firmly embedded in psychoanalytic understanding of mental processing.

Psychoanalytic "diagnosis" is necessarily idiosyncratic, reflecting as much the style, preconceptions, and creativity of the analyst as the unique problems of the presenting patient. While this is frustrating for researchers, it reflects clinical and

existential reality. A different assessor might have formulated the above-described case differently (Perry, Cooper, & Michels, 1987): a Kleinian formulation might have placed much greater emphasis on aggression, with the accident representing John's primitive split-off destructiveness, uncontained by his abandoning mother, his depression a manifestation of a harsh superego bent on punishment and revenge. A self-psychologist might have focused on the mirroring aspect of the transference in which the therapist felt stirrings of omnipotence similar to those that John himself resorted to in the absence of a consistent nurturing self-object. At the same time, there are clearly similarities between each approach, albeit couched in the different languages of the distinct traditions within psychoanalysis.

Despite the difficulties of categorisation, most psychoanalysts use some sort of developmental schema (see Chapter 3) as a way of understanding patients diagnostically, indicating the severity of their problems, guiding treatment, and predicting prognosis. Indicators of the severity of psychological dysfunction are often considered, while the distinction between oedipal (three-person, less severe, neurotic) difficulties and pre-oedipal (two-person, more severe, borderline and narcissistic) problems is used by some clinicians as an indicator of likely difficulties in treatment. However, in practice it is not always easy to decide the level at which the patient is operating, nor indeed whether deficit or conflict is the major theme. John's level of adjustment was undoubtedly "neurotic" (i.e., three-person) rather than borderline – he had a stable marriage, work pattern, and general level of maturity. Yet, his illness threw up pre-oedipal narcissistic issues, which he had successfully buried since early childhood. Abandoned by his parents, he suffered from a "deficit", and yet his transference was conflictual – he was angry because of the deficit.

Ego psychology emphasises the maturity of defences as a guide to developmental level. Vaillant's (1986) hierarchy of defences, ranging from primitive (e.g., splitting) to immature (e.g., "acting out"), neurotic (e.g., obsessionality), and mature (e.g., humour), provides a useful framework (see Chapter 4). Zetzel (1968) tries to capture the essence of "analysability" in terms of levels of trust, capacity to cope with loss, and ability to distinguish between inner and outer reality. She distinguishes between the "good hysteric" (whom she, wrongly, assumes to be female) at one end of a developmental spectrum, whose hold on reality is firm but who suffers from oedipal inhibitions of desire, and, at the other, the "so-called good hysteric", whose relationships are shallow and who, behind her longing for satisfaction with a man, is in constant search of a nurturing breast.

Kernberg's (1984) Kleinian object-relations diagnostic schema sees the two fundamental developmental tasks as the taming of aggression and the achievement of emotional whole-object constancy. Those with severe narcissistic disorders can neither tame their aggressive and genital drives, nor escape from splitting, and are rarely suitable for psychoanalysis but may

respond to modified psychoanalytic intervention (Stern, Diamond, & Yeomans, 2017). In Kernberg's model of moderate narcissism, the individual is promiscuously dominated by "part-object" relationships, treating whole people as though they were breasts, penises, or lavatories. In borderline conditions, the object is whole but unstable and not properly integrated, thus alternately idealised and denigrated. Neurotic individuals have stable, integrated relationships but are genitally inhibited. The mature (successfully analysed?!) individual can integrate genitality into a loving relationship and harness aggression appropriately while still relating to others as whole beings. Helpful though this Kernbergian schema is, it should be noted that it contains an implicit ethical/moral schema, transmuted into a quasi-scientific and objective classification.

Selecting patients for psychoanalysis

Implicit in the foregoing is the implication that there is no simple formula that will decide whether someone is "suitable" for psychoanalysis, although diagnostic schemata are useful in pointing to possible pitfalls and suggesting the technical approaches that might be helpful. The decision will always be contextual in the sense that it will depend on the relationship between analyst and patient, and their mutual circumstances. If a psychodynamic inpatient or day-patient setting is available, then more acutely ill patients can be treated psychoanalytically than would be possible in private office practice. Another contextual dimension is age. Freud (unlike Jung) cautioned against analysis for those over the age of 40 years, whom he felt lacked the necessary flexibility of mind to change – which is curious, since it was only when he himself reached his forties that he invented psychoanalysis. It is now clear that older people can be successfully treated (Couve, 2007; Valenstein, 2000), and indeed an increasing proportion of psychoanalytic cases comes from this age group, not least because they are able to afford such an expensive and intensive treatment. In sum, "analysability" is not an objective criterion, but an interactional and even sociological phenomenon.

Thomä and Kächele (1987) contrast two apparently contradictory statements on the subject made by Freud (1905b) (our italics):

> To be quite safe, one should limit one's choice of patients to those who possess a *normal mental condition*, since in the psycho-analytic method this is used as a foothold from which to obtain control of the neurotic manifestations. (Freud, 1905b, p. 263)

But:

> Psycho-analytic therapy was created through and for the treatment of patients *permanently unfit for existence.* (Freud, 1905b, p. 262)

Thomä and Kächele reconcile these two statements with the aphorism "sick enough to need it, healthy enough to stand it". The inclusion and exclusion factors listed by different authors guide the assessor to find the balance between illness and need on the one hand, and healthy robustness on the other. The idea of the "transference neurosis" captures the essence of the requirement: if psychoanalysis is to succeed, the illness must both manifest itself, and be contained, within the therapeutic alliance. Malan's (1979) "law of increased disturbance" also applies here: during the course of treatment, the patient is likely to manifest his most disturbed level of functioning. Drawing on Winnicott, Casement (1985) sees this as necessary, if the patient is to bring the original trauma "within the area of omnipotence".

Factors favourable or unfavourable to psychoanalysis fall under three headings: evidence from the history, from the content of the interview, and from the style and approach the patient takes to talking about himself (Malan, 1979; Tyson & Sandler, 1971). A history of at least one good relationship (evidence of "basic trust"; Erikson, 1963) and of some positive achievement is encouraging. Addiction, serious destructive or self-destructive behaviour suggesting poor frustration tolerance; a history of prolonged psychotic breakdown in the face of stress; or entrenched somatisation (with concomitant "secondary gain") are all relative contra-indications to unmodified psychoanalysis. People with severe obsessional neuroses, although originally considered treatable psychoanalytically (Freud, 1909), are best treated with a combination of medication and cognitive-behavioural therapy, but obsessional personalities are commonly treated psychoanalytically. Given the existence of a fairly wide range of effective symptomatic treatments (cognitive-behavioural and pharmacological), many of the patients taken on for psychoanalysis are also likely to have character disorders, that is, enduring dispositions to problematic relationships, which underlie intermittent illnesses such as depression or anxiety disorders, and which need more than symptomatic treatment if these self-defeating or destructive patterns are to be modified.

As we have discussed, key features in the content of the interview are the patient's capacity to form a working alliance, and his affective response to trial interpretations. The patient's narrative style will reveal how "psychologically minded" or "accessible" he is, terms that summarise a range of psychological functions: the capacity to see oneself from the outside (Sandler, 1992), to reflect on one's inner world (Coltart, 1986), to tolerate psychic pain, to regress in the service of the ego (Kris, 1956), "autobiographical competence" (Holmes, 1992), "fluidity of thought" (Limentani, 1972), self-reflective function, and mentalising (Bateman & Fonagy, 2019).

Finally, the elusive dimension of *motivation* is probably crucial. The patient who has sought out treatment, who wants it badly, is prepared to work at it, and who views the process and his analyst in a positive light is likely to do well, overcome setbacks, make sacrifices, and cope with regressions.

Perhaps this is what Freud (1912) meant by the need for the patient to have a good "ethical development", and what Symington (1993) refers to as an essential spark of goodness that counterbalances the "internal saboteur" of the narcissist. Here, the analyst is a guardian and champion of that push towards health that coexists with the bleak landscape of neurosis, a hopeful possibility that defies classification yet forms the germ of a successful therapeutic relationship.

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Chapter 8

The therapeutic relationship

> The resistance accompanies the treatment step by step. Every single association, every act of the person under treatment must reckon with the resistance and represents a compromise between the forces that are striving towards recovery and the opposing ones. (Freud, 1912a, p. 103)

The idea of a therapeutic relationship is present in the patient's mind long before analysis begins. He or she knows something is wrong and begins to wonder how it can be put right; or, at a deeper level, may already be having conversations with an imaginary analyst as a way of alleviating a lonely inner world. The future patient begins to talk to friends or professionals and gradually, sometimes via psychotherapy, at other times through a recommendation, and occasionally as a result of bad experience in other treatments, moves analysis-wards. There may already be a mental image of the kind of person that he or she feels will be helpful – gender, age, ethnicity, warmth, and so forth – a relationship waiting to be actualised in the transference. As in all walks of life, analysts defy stereotypes and come in all different shapes and sizes. The bearded, white-haired, cigar-smoking man, sitting behind a couch surrounded by relics of antiquity, and poised with pad and pencil, is legendary but obsolete. However, just *any* analyst will not do. Research suggests that patient–analyst "fit" or congruence has a significant impact on treatment outcome and, as we will see in this chapter, analysts vary greatly in their personal style, even though they adhere to basic analytic technique.

The therapeutic contract

Whether the potential patient is naive or informed, the analyst has a responsibility, therapeutic and legal, to set up a contract – typically verbal and informal – and to specify certain conditions before treatment begins. He must explain what analysis involves, how long it is likely to last, the risks

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and possible benefits, cost, any particular "rules", and the rationale that he follows.

Ideally, both patient and analyst are clear about their objectives and expectations, and aware of possible difficulties so that future misunderstandings are minimised. But, of course, the very difficulties that bring people for help means that their capacity to do these things may be compromised. Contracts are honoured as much in the breach as the observance, while difficulties are grist to the transferential mill. For example, the patient may not "hear" the analyst say that the patient will be expected to pay for sessions to which he does not turn up. It is not sensible to embark on analysis if the patient's employer may be posting him or her abroad within the next 6 months, but the patient may believe that 6 months is an adequate length of time for treatment, and unless this has been discussed beforehand, the analyst might inappropriately interpret resistance when the inevitable move takes place.

The spirit rather than the letter of the therapeutic agreement is what matters. A patient who requests a change of session may be offered an alternative if he has an unavoidable commitment such as a child's hospital appointment, or is taking an exam, but not if he simply arranges an "unavoidable" meeting at the time of the session! In this case, he is betraying the spirit of the agreement that both patient and analyst adhere to their arrangements and vary them only by joint discussion. This places equal obligation on both patient and analyst not to alter the framework of treatment unilaterally.

J.H.'s supervisor, the psychoanalyst Michael Balint, told the following, probably apocryphal, story. The patient announced to his analyst that he would be missing his next session as he had decided to shoot his boss on that day (this was in the United States where, of course, thanks to gun law, such things are not uncommon!). To which the analyst replied, "Do what you like with your spare time, but don't use that as an excuse for missing a session".

The couch

Freud (1912b, 1913) made particular recommendations about the setting that he found useful, despite admitting that they may not suit all analysts or all patients. Nevertheless, his proposal that the patient lie on a comfortable couch in a warm room remains for many a *sine qua non* of analytic technique (but see Schachter & Kächele, 2010), even though the psychoanalytic setting, including use of the couch, as core to psychoanalysis has been further challenged through offering psychoanalytic treatment by telephone or online (see Chapter 12). The patient may know about the couch but express surprise at lying down, believing it to be outdated and anachronistic. Often, reluctance is a manifestation of frightening regressive or sexual phantasies, and of revealing vulnerability. Patients may need to be encouraged, for

example, by saying that lying down frees both themselves and the analyst to think, unencumbered from the normal visual cues of human discourse, and that their removal loosens the control on unconscious processes. Nevertheless, for some patients, especially those with borderline syndromes (see Chapter 10), an initial period of face-to-face therapy may be needed before they feel safe enough to "disappear" into the couch.

Example: An upright young man

A rather formal 23-year-old man told his male analyst that he was not going to lie down as "it seemed silly". After some months of face-to-face contact, the patient had a dream in which a burly man came up from behind, raised a large stick and stuck it into him. Associations to the dream suggested that the patient was terrified that the analyst would attack him if he lay down; later this linked up with homosexual anxieties.

The use of the couch has been questioned by some analysts. Adler (1956) felt the couch compounded the patient's feelings of inferiority, while Fairbairn (1958) considered it a dehumanising remnant of Freud's hypnotic technique, and instead advocated a face-to-face arrangement. Although its use is standard technique, the "angle" of the analyst vis-a-vis the couch is more a matter of style. Some sit completely behind the patient, well out of the line of sight, while others position themselves more to the side. Given the "apostolic succession" (Balint, 1968), this may have as much to do with the way analysts' own analysts positioned themselves as any valid therapeutic rationale.

The setting

Many hours are wasted over arguments that confuse analytic technique with style. Each analyst sets their own style: the way they furnish their consulting room, greet their patients, finish sessions, give bills, and announce breaks. Together, these form the "setting", designed to communicate and contain a set of counterpoised themes: attachment and separation; revelation and closure; gratification and frustration. Together with the couch, the generally accepted elements of psychoanalysis include sessions of 50 minutes three to five times a week (attachment and continuity), weekend and holiday breaks (stimulating separation anxiety), the use of free association (unconscious expression), an open-ended contract, adherence to the agreed arrangements (holding), protection from interruption (containing), neutrality, and the "rule of abstinence" (frustration).

Length of session

Debate has raged over analysts who have challenged these fundamental ingredients of the analytic approach. Winnicott (1977) would at times offer "analysis on demand" including prolonged 2- or 3-hour sessions, encouraging pathological dependence and regression. At the other extreme, Lacan introduced the "short session", in which he would abruptly terminate a session after a few minutes (Fink, 2011; Miller, 2000; Schneiderman, 1983). His justifications, it seems, were that the main work of analysis occurs between sessions, and that since the unconscious does not comprehend time, at least in the "clock" sense, a 10-minute session may carry as much weight as the conventional 50-minute "hour". Against this method, which, according to Fink (2011) has largely fallen into disuse except among Lacanian extremists, are a number of cogent arguments. It interrupts the free flow of free association; raises anxiety to inhibitory rather than stimulating levels; is a form of anti-therapeutic analytic acting out (see Chapter 9), because if things are difficult or uncomfortable the tendency will be to shorten the session; short-cuts the thoughtful use of countertransference; and places the analyst in a "one who knows", judgmental position.

Rules may be made to be broken, but such heterodoxy is best reserved for mavericks and masters. The preferred course for ordinary mortals is to stick to the "50-minute hour", even if the patient is distressed at the end of a session. This may need to be acknowledged, and the important thing is for it to be explored in good time at the next meeting.

Free association

Free association is more easily recommended than performed. The standard invitation runs something like: "I suggest that you talk about anything that comes into your mind, however irrelevant or inappropriate it may seem, including thoughts and feelings you may have about being in treatment or the sessions themselves". This acknowledges that patients will almost certainly censor some thoughts and feelings, especially if they are about the analysis or the analyst himself, and encourages them to put them into words. In this way some acting out (see Chapter 9) may be avoided. However, such an invitation can be intimidating. As one patient put it: "If I could do that I wouldn't need to be here in the first place" (Rycroft, 1979).

The "rule of abstinence"

This rule, as put forward by Freud (1915), is somewhat paradoxical for both patient and analyst. For Freud, there were in fact two contrary "rules": (a) that the *analyst* should not satisfy the patient's desires in the analysis, and (b) that the *patient* should not look outside the analysis for gratification.

Arguably, the tension between them provides much of therapy's mutative power.

For analysts' abstinence, there are two aspects. First, the patient will inevitably be curious about the analyst – his or her life, beliefs, interests, education, history, and so on. Aspects of these will be self-evident in the ambiance of the consulting room and the analyst's appearance, clothing, mannerisms, age, gender, accent, presence or absence of a wedding ring, etc. But beyond this, the analyst remains an "enigmatic signifier" (Heenen-Wolff, 2013). Despite some relational analysts who argue to the contrary (Aron, 2003), the mainstream view would be that analytic reticence is the preferred mode and that what matters are the motivations and phantasies behind questions, rather than to answer them. Direct answers to the patient's demands for information – "Are you married?", "How many children have you got?", "Do you ever get depressed?", and so on – shift the focus away from the patient, tether the analytic process in the concrete rather than in phantasy, and interfere with free association and the exploration of transference. Clearly, in some instances acknowledgement of reality is unavoidable, for example, if the analyst becomes seriously ill or pregnant. As Winnicott once remarked, it is important to remember that we are human beings first and analysts second. Equally, we should not forget that our patients are people first and analysands second.

The second aspect of analysts' abstinence is the obvious and absolute prohibition on forming a non-analytic relationship, and especially a sexual one, with their patients. This should go without saying – but needs to be emphasised because sexual abuse of patients by analysts is a recognised and documented extreme example of "boundary violation" in therapy (Gabbard, 2016). Although this sometimes simply reflects psychopathology, it may occur with poorly supervised analysts who embark on the "slippery slope" to abuse via well-intentioned wishes to "help" their patients, perhaps starting with a friendly hug or agreeing to meet for coffee. Often these analysts are themselves experiencing a crisis in their lives – divorce, depression, debt – and are in the thrall of their enacted countertransference rather than recognising and drawing on it for therapeutic ends.

At a more everyday level, analysts should be aware of and learn to curb their therapeutic fervour or wish to cure, imposition of personal values, or secret pleasure in countertransference experiences. On the other hand, analytic "neutrality" may conflict with clinical sensitivity. All analyses contain occasional supportive elements, such as reassurance and commiseration, in addition to the implicit support of the secure setting and the analyst's attention and empathy. Minor "gratification", for example, allowing a soaking wet patient to dry himself, as long as it remains within an ethical framework, may at times be needed if the analysis is to progress or even survive (see Chapter 9). The point is not so much to avoid gratification

at all times, but to explore its transference and countertransference implications whenever it occurs.

The rule of abstinence as applied to analysands was put forward by Freud at a time when analysis was seen as a 3–6-month enterprise. As analytic months have become years, and in our more democratic age, it may appear prescriptive and authoritarian. Nevertheless, it is important that a patient who experiences unsatisfied needs in relation to the analyst – as they almost inevitably will – does not simply seek satisfaction elsewhere, as with the patient who precipitately gets married during their analyst's summer break. Nevertheless, major life changes for a patient, such as marriage or a change of job, will occasionally occur during the course of an analysis, and it is probably better to tease out their meaning, rather than issue an unenforceable prohibition at the beginning.

The treatment process

Rustin (2001) argues that Freud's creation of the analytic setting was a "technological" innovation comparable to the discovery of the telescope or, in our time, the magnetic resonance imaging scanner, opening up a whole new realm of human experience for examination and understanding. The aim of the setting is to create an analytic *space* and to contain a *process.* Modification of the setting interrupts the underlying process and should be avoided if possible. However, minor changes such as the unexpected absence of the analyst through illness, lateness, change of consulting room, and alteration of fees are inevitable, and may stimulate new material. Given firm boundaries of a stable setting, these events can be productively explored and their meanings highlighted.

Once the parameters of the relationship have been established, the scene is set for treatment to begin, usually with a combination of optimism and trepidation on the part of both participants. Patients typically start by explaining a great deal about themselves, their history, current dilemmas and conflicts and miseries – fearfully at first, but then with increasing confidence, looking to the analyst for clarification, sympathy, and help. But gradually, nagging doubts about treatment may intrude, especially if the analyst fails to behave or intervene in the expected or desired way. Anxiety increases, fears are heightened and patients begin to think they may have made a mistake in seeking treatment. Early optimism and hopes of a rapid resolution begin to fade. Patients may wish they had never started on such a course and feel they were either foolhardy or naive.

Analysts' refusal to fulfil patients' demands – their adherence to the "rule of abstinence" – evokes gradual disillusionment. The resulting frustration triggers reversion to earlier, more archaic patterns of relating: therapeutic *regression* begins to emerge, as wishes, phantasies, hopes, desires, disappointments, frustrations, and longings, present and past, come to the fore.

To the extent these are embodied in the analytic relationship, highlighted by the setting, their nature and origins can be studied and understood. The analyst's task is to allow this transferential anxiety and frustration to increase to a level that encourages the emergence of childhood patterns of feeling and behaviour, without being so overwhelming that patients abandon treatment or revert to familiar evasive ways of dealing with mental pain.

The analyst's role

Bion (1967) famously pronounced, half-quoting T. S. Eliot, that analysts should approach each session "without memory and desire". At the time, this was perhaps a necessary antidote to the analytic tendency to assume theory-derived "one who knows" omnipotence. Today, it is more a reminder to analysts of the importance of clearing their minds of preconceptions, and attending to their patients with freshness and receptivity – a genuine curiosity.

We advocate a "triple listening" stance in which the analyst: (a) creates within him/herself a receptive empty space within which the patient's fears, phantasies, and phobias can safely be contained and scrutinised; (b) listens to themselves listening – that is, attends to countertransference via "free-floating" (Sandler, 1992) or "evenly suspended" attention (Freud, 1912b); and (c) listens to themselves being listened to – that is, closely monitors how the patient responds to interventions and, where necessary, modifies their pitch and tone accordingly.

Analysts need to cultivate the capacity to allow their mind to wander, reflect on why particular thoughts arise, and tolerate feelings rather than avoiding them, oscillating between empathic primary identification and objectivity, representing (perhaps) traditional maternal and paternal roles, respectively. Each analyst tries to strike a balance between silence and speech and to vary the "dosage" of interpretations appropriately. Britton (2013) suggests the analyst needs to cultivate a stance akin to Keats's "negative capability" (Keats, 1891), describing the analyst's attitude as one of constant uncertainty and doubt mixed with naivete and compassion, and always with focused concentration. Using free-floating attention, the analyst's mind alights on a particular topic, which then acts as the central point around which exploration takes place. Inevitably, this can become derailed by transference and countertransference responses and even by over-valued ideas of the analyst.

However, different schools and their leaders advocate different approaches. At one end of the spectrum is Balint (1968), who argued that it was important to intervene as little as possible (although in practice he was far from faithful to his own precept; D. Ball, personal communication, 1985). At the other extreme lie those for whom interpretation is the lifeblood

of their work (Etchegoyen, 1991). Between are authors such as Winnicott (1965), who emphasised the importance of non-intrusiveness and respecting the patient's ultimate privacy, and Green (1975), who argued that excessive speaking *or* too much silence are equally harmful, leading either to intrusion and control, or to unproductive anxiety and feelings of abandonment. Inevitably, analysts get things wrong and there will be analytic ruptures, great or small. But the analytic process is assisted by the gradually strengthening therapeutic alliance (i.e., a generally positive attitude towards treatment on the part of the patient; see Chapter 7), which enables mistakes and inaccuracies to be tolerated and ruptures to be repaired (cf. Safran, Muran, & Eubanks-Carter, 2011).

Mutative ingredients

What, then, is the main task of the analyst in the analytic process? To reduce conflict and encourage more effective use of mature mechanisms of defence (see Chapter 4)? Establish a continuum between the there-and-then and the here-and-now? Understand and give insight? Offer a "corrective emotional experience" (Christian, Safran, & Muran, 2012; see below)? To facilitate a "new beginning" (Pedder, 2010) through regression? How do the analyst and patient work together to achieve any of these goals? Is it enough to allow the analytic process to take its course, relying on the security of the setting and the analytic relationship to bring about change, or is specific and accurate interpretation needed? If the latter, what form should it take? Should it be a dynamic interpretation in the present or a genetic reconstruction of the past? How far should all interpretations address the transference–countertransference dynamic, or are extra-transferential interpretations also useful?

The answer surely is that all, and more, are needed. The analyst's craft is to distinguish which approach is most appropriate for which patient and at what time. Each individual brings his own unique life to the therapeutic process and forms his own treatment pattern. In an attempt to address some of these questions, we will now turn to some of the central themes of the analytic process: *regression*, *resistance*, *interventions*, *interpretations*, *insight*, *working through,* and *termination*.

Regression

Retreats often precede great leaps forward. Regression can be defined as returning from a point in development already reached to an earlier one. Freud (1900) distinguished between three kinds of regression: topographical, formal, and temporal. *Topographical* regression refers to the move from secondary to primary process, from action to phantasy. Thus, in dreaming, consciousness is in abeyance while the realm of the unconscious is

unchallenged by the need for reality testing. The regressive pull of the analytic setting means that the patient's conscious communications are continuously modified by unconscious phantasies, thoughts, and feelings. *Formal* regression, in which there is a "harking back to older psychical structures" and a use of "primitive methods of expression", is a common characteristic of the psychoanalytic process. Under stress, patients revert to primitive defence mechanisms, and may behave in childish ways, or move from the depressive position to paranoid–schizoid functioning (see Chapter 4). *Temporal* regression refers to specific phases of childhood development. In Freud's model, as the child moves through different psychosexual stages, vestiges of the earlier stage may be returned to in the face of disappointment, frustration, or emotional difficulty. He saw these points of return as "fixation points" (Freud, 1916).

Sandler and Sandler (1994) saw these distinctions as somewhat artificial, and indeed Freud (1900) himself claimed that they are "one at bottom". They proposed that regression be seen as counteracting the "anti-regressive function" of the ego. The ego's at times Herculean task is to maintain civilised and independent behaviour even under duress or provocation, and to control unacceptable impulses and needs, while still allowing appropriate expression of emotions. In their balanced view, alongside the "anti-regressive function", psychological health requires a capacity to *release* healthy regression and allow latent, often infantile, wishes to be expressed.

Example: The terror of the needy child

A withdrawn man, with schizoid traits, who had been brought up in an orphanage, was referred for analysis. During the assessment, he spoke of how he worked hard, had little social contact, and had never had an intimate relationship. He felt he could never rely on anyone. He described how he had invited a girl out to supper and, although she had agreed to come, she failed to turn up at their "date". He attempted suicide that evening. The analyst tried to point to the conflict between his fears of dependency and involvement, and yet how he would rather die than experience abject loneliness, rejection, and humiliation. The patient responded by saying he would never give anyone the satisfaction of thinking that he needed them. Sadly, but perhaps unsurprisingly, he rejected analytic treatment.

Rigid maintenance of the anti-regressive function of the ego is a potent source of resistance in analysis, but fortunately such an extreme example of detachment and tenacious control of emotions is fairly rare. As a patient talks and the analyst refrains from excessive interruption in the form of both

comforting remarks and critical or judgmental comments, the patient's less conscious wishes, half-remembered experiences, and earlier expectations come to the fore as though they at last had found an opportunity of expression. This benign regressive trend occurs in waves and cycles during analytic treatment, at one moment being apparent, the next retreating to be replaced by more adult functioning. It allows patients to explore and begin to emerge from their childhood "retreats" (Steiner, 2011) in the safety of the analytic setting. Kris (1956a) characterised this "regression in the service of the ego" as part of a continuing intrapsychic oscillation between present and past, so that the adaptive abilities of the ego in the present are informed by experience from the past.

Balint (1968) pointed to the interpersonal aspects of regression. Analysts vary in their propensity to encourage regression, a personal quality dependent on a tender acceptance and lack of anxiety in the face of primitive emotions. He claimed that Ferenczi-type "active techniques" (Harris & Kuchuck, 2015) are neither desirable nor necessary. Lying on the couch and the silent presence of the analyst are sufficient to release a regressive pull. During "normal regression", patients remain in touch with their curiosity, ability to experience feelings, and capacity to observe, and rapidly regain equilibrium, with the help of the analyst's interventions if needed. The therapeutic alliance should always be maintained. Patients may demand love, crave affection, and require appreciation from their analyst, but seldom reach a point where they cannot function without them. The transference relationship allows wishes, phantasies, and feelings from the past to be revived in the present; the neutrality of the analyst encourages patients to express themselves without excessive reasonableness and to converse unencumbered by social politeness, fairness, and consideration.

However, if frustrations are too great and demands become excessive, the regression becomes countertherapeutic and may even lead to a breakdown in treatment or a hospital admission. Now, the analytic relationship becomes imbued with grandiose phantasies or dependency needs that cannot be met, alternately idealising and denigrating, indicating that the line between therapeutic and "malignant" regression has been transgressed. Dangerous acting out and a loss of sense of reality are not far off, and the analyst may be pulled into an escalating spiral of pathological transference–countertransference reactions, in which he either "gives in" or tries to pull away, while the patient scents possible gratification of his infantile desires.

Balint (1968) and others (Ornstein, 2002; Sklar, 2017) link regression to the possibility of a "new beginning" in which past traumas are corrected through the transference relationship. Balint considers that in every serious mental or psychosomatic illness there is a *basic fault*, arising in the earliest mother–child relationship, and that help lies in correcting this deficit by

addressing the preverbal, empathic, and wordless aspects of regression through experiencing rather than interpreting. The patient needs to regress:

> either to the setting, that is, to the particular form of object relationship which caused the original deficiency state, or even some stage before it. (Balint, 1968, p. 166)

The regressive analytic situation allows the patient to re-experience the pain of there-and-then within an attentive and benign relationship, and so to heal over the traumatic scar from the past. For Winnicott (1971), analysis provides a "holding environment" or transitional space in which early experiences can be regressively reworked, leading to greater creativity and increased self-understanding (see Chapter 6). This is not far from the idea of the "corrective emotional experience", a phrase that was originally proposed by Alexander and French (1946) but fell into disrepute in analytic circles because of its exploitation by ethically dubious practitioners. Discussion about the role of regression continues to shape debate between proponents of emotional experience versus interpretation, relationship as opposed to technical skill, the affective rather than the intellectual content of analysis.

In these discussions, the all-important patient's point of view can get lost. Re-experiencing earlier difficulties is intrinsically painful, even for those attracted to analysis by its regressive possibilities. Our patients are survivors. For good or ill, they have found ways of adapting to past difficulties – intellectualisation and rationalisation are great pain-blockers, not to mention substance and alcohol abuse, compulsive sexuality, and other forms of risk-taking. The patient may yearn to live more happily and to improve, but the thoughts, desires, and needs that analysis throws up bring with them embarrassment and shame. Part of the patient will feel better with symptoms than without them. The anti-regressive function hardens and becomes a source of resistance (Sandler & Sandler, 1994). A state of conflict may then develop in which patients feel pushed and pulled between the relief of expressing long-buried feelings, and resisting change: "and always keep a-hold of Nurse, for fear of finding something worse" (Belloc, 1907).

Resistance

From a patient-centred perspective, Freud's notion of "resistance" as stated at the start of this chapter is a problematic concept. It refers to the ways people obstruct the very analytic process on which they rely to help overcome their difficulties. Resistance takes many forms, ranging from conscious concealment of facts to unconsciously driven acting out (see Chapter 9), from affect-free intellectualisation to incontinent "emoting", from missing sessions to obsessional punctuality, from talking exclusively about the analytic relationship to dismissing its relevance, from erotising the relationship

to deadening it, from developing new symptoms to rapidly losing the old and taking a flight into health.

Freud (1926) classified resistance into *repression resistance*, *secondary gain resistance*, *transference resistance*, *repetition-compulsion resistance*, and *superego resistance*. Other aspects of resistance include "character resistance" (Reich, 1933), maintenance of grandiose self-esteem in borderline and narcissistic patients (Kernberg, 1988; Kohut, 1984; Rosenfeld, 1971), the preservation of a fragile identity (Erikson, 1968), the imperative of internal safety (Sandler, 1968), and continued splitting to avoid overall integration of experience (Thomä & Kächele, 1987). We will look in detail at some of these.

Repression resistance

Repression resistance arises from the need "not to know" – in Bion's terms, "minus K". The emergence of memories, past feelings, and phantasies threatens to destabilise the patient's internal equilibrium. The closer the analyst's interventions bring the repressed contents of the unconscious to the surface, the greater the danger to the patient and the greater the resistance. The analyst must pitch his interventions so that they allow repressed content and affects to surface in a way that is tolerable to the patient. These buried feelings may themselves become a resistance, and, in "*secondary gain*", the resulting symptoms become a way of life in themselves.

Example: A cruel sickness

A depressed patient developed nausea and a persistent feeling of fullness in her stomach soon after starting analysis. She complained of feeling bloated and blamed the analyst for her symptoms. She claimed that analysis was detrimental to her health, deriding its failure to help her physical condition. She turned to her general practitioner, but drugs gave no relief. The beleaguered analyst felt stuck and even that the patient was enjoying her constant attack. He interpreted her wish for him to "look after" her physically, her disappointment that he did not, and that she felt he was "force-feeding" her with his interpretations. While this comment was no doubt partially correct, it missed the sado-masochistic suffering with which she punished not only herself but also those purporting to help her. This linked with her childhood, in which her lone-parent mother had been a chronic invalid, demanding that the patient wait on her and respond to her every beck and call. With supervisory help, the analyst realised that a transferential scenario was being played out, in which he was occupying the role of the helpless child vis-à-vis an invalid and

invalidating mother. He suggested to the patient that she was showing him just how desperate and lost and unsupported she felt as a child. This shifted the resistance to the extent that the patient could begin to feel her feelings of fear and rage as affects rather than somatisations, and to move to a more appropriate, albeit regressive, dependency on the analyst.

Transference resistance

Transference resistance places the concept of resistance within the therapeutic relationship and often takes the form of hostility or indifference to the analyst–patient relationship, or to any mention of it. Patients will dismiss attempts to make links between their narrative of events in the outside world and the therapeutic situation. There may be an analytic counterpart in the form of "counterresistance" (Stone, 1973), in which the analyst gradually disengages emotionally from the patient, buttressing themselves with denigratory terms such as "malignant regression" or "borderline pathology". There always needs to be a degree of mutual accommodation between patient and analyst. Even if this is successful, patients may develop powerful, uncontrollable aggressive or erotic feelings towards the analyst, which eventually lead to disappointment and drop-out (see Chapter 10). At a loss to explain the failure of some analyses, Freud (1920) attributed such "malignant" resistances to "*repetition compulsion*", which he saw as a psychobiological phenomenon insisting on stasis at any cost (cf. Barratt, 2019).

Superego resistance

Superego resistance refers to the process by which some patients masochistically accept their lot in a long-suffering way, with little apparent wish to change. In Freud's (1918) "Wolf Man" case, he noticed that every time progress was made, the symptoms seemed to return – often with a vengeance. At first, he saw this as mere defiance, but then thought of it as a *paradoxical reaction* to the accuracy of his interpretations. This is the *negative therapeutic reaction* (Freud, 1923), an unconscious masochistic tendency, in which the aggressive superego will not "allow" the patient to escape health-wards from its iron grip.

Negative therapeutic reactions can be thought of as assertions of autonomy: "I'll find out in my own good time and not when you want me to understand"; a wish to remain dependent: "If I start to get better that means I'll have to leave"; or envy: "I can't bear to accept that you could understand so much about me". A less motivational explanation would be that giving up established defences arouses anxiety, and until the patient fully trusts the

analyst (and himself) to manage the anxiety and arrive at a more mature set of defences and a more complex psychological organisation, "clinging to the wreckage" may seem the safer option. In general, the concept of resistance can be formulated in terms of "rupture and repair" (Safran et al., 2011). Whatever form it takes, resistance should be attended to and forms a point of therapeutic leverage. Where patients are most stuck is where they most need to change.

Example: A stickler for time

A 30-year-old woman had had near-fatal asthma as a child, and had been raped in her teens. She looked at her watch at regular intervals throughout her sessions and always insisted on finishing one minute early. Confronting her need to control the ending of sessions (the analyst pointed out that, although analysis was hard work for her – she had to turn up regularly, learn to free associate, face her fears, etc. – ending sessions was his "job", not hers), and relating this both to the terror she had experienced during the rape and her inability to relax in the presence of her excessively anxious mother, led to greater trust in the relationship.

Eventually, she took her watch off for the duration of the session. Later, once she was more in touch with her emotional needs, she was able to leave it on, and allow the analyst to bring the session to a close. She did, however, unilaterally decide on termination, although by this time she was much improved, and was able to discuss her fears and her sense that she had had her "fair share" of focus and attention.

This, incidentally, probably meant she still felt deprived. At a deep regressive level, there is a need for a boundless love, and "fairness" does not – and probably should not – enter into the analytic equation.

The spectrum of therapeutic interventions

Psychoanalysis has from the start swung between seeing either insight and interpretation or the emotional relationship with the analyst as the main vehicle of cure. This polarity, creative at times, has divided analysts, creating different schools and provoking bitter schisms. As mentioned earlier, in the 1950s Alexander's use of the "corrective emotional experience" was discredited, and interpretation gained the high ground. Then, Balint and Winnicott reaffirmed the importance of "new experience", especially in dealing with pre-oedipal problems. Wolff (1971) contrasted the analytic "being with" and "doing to" roles, considering them of equal importance.

"Being with" the object depends on the more receptive female element, and "doing" something to the object depends on the more active male element, although of course both are present in analysts, whatever their gender. If "doing to" is overdone, it may deprive the patient of a chance to discover his own answers and solutions, and thus interfere with the developmental process. In contrast, too much "being with" may fail to provide the necessary challenge and intellectual rigour needed to promote growth.

The debate continues. Contemporary Freudian and Kleinian psychoanalysts emphasise interpretation, while self-psychology, relational, and independent approaches see non-verbal empathy and attunement as intrinsically therapeutic. Kohut (1984) contrasted the *content* of an interpretation with the *way* it is given. He asserted that even if the content was wild or inaccurate, the interpretation could be effective if given in the right tone of voice (cf. Chapter 1).

Seen from the realities of the consulting room, this dichotomy looks contrived: analytic matter and manner are intertwined and inseparable (Wallerstein, 1992, and see later in this chapter). The security of the setting and the restrained, attentive listening of the analyst form part of the background of treatment, enabling patients to consolidate embryonic feelings of trust, and to identify with and begin to internalise a helpful, considerate object. This in turn enables them to become more thoughtful about themselves and, provisionally at least, to accept interpretations. The analyst's containing function (Bion, 1959, 1962, 1963) is key to this process, collecting and integrating projected aspects of the patient's self. The analyst's capacity to understand and give meaning to these projected fragments allows them to be transformed into a more tolerable form and re-introjected, and to contribute to an enhanced and expanded sense of self.

The art and craft of psychoanalysis consists of finding the right balance between "being with" and "doing to". Overvaluation of transference interpretation has led to the neglect of other factors such as affirmation, validation, and even praise and support. Whatever their theoretical allegiance, most successful analysts work in a flexible way as the balance between interpretive work and supportive interventions shifts back and forth throughout treatment from support, affirmation, reassurance, and empathy to encouragement, elaboration, clarification, confrontation, and interpretation.

In general, the closer the intervention is to the interpretive pole of the continuum, the more "psychoanalytic" the treatment is, while *support*, *affirmation*, and *reassurance* are typically transmitted via regular "mm-hmm"s and "aah"s, which encourage elaboration or stimulate further exploration. Although they may be transferentially so perceived, analysts are neither inhuman nor superhuman. Most will offer an appropriately sympathetic response in the face of some personal setback or bereavement. Such interventions, as well as mild interjections or sympathetic grunts, demonstrate

that the analyst is still present, alive, listening, following, and trying to understand (Rycroft, 1985).

Empathy is a demonstration of the analyst's attunement to the patient and, although often wordless, may take the form of statements such as "Listening to you, it sounds as though you felt really hurt when you were treated in that way". It seems unlikely that one school of analysts is more empathic than another, but in self-psychology (Kohut, 1977, 1984), empathy is seen as pivotal rather than merely a precursor to interpretation. This emphasis on empathy may have arisen to counterbalance the rather rigid interpretive technique of some ego psychologists, but it also represents a shift from conflict to deficit as a central theoretical theme (see Chapter 3).

Moving along the spectrum of interventions, *elaboration* is usually used as a prelude to clarification or even confrontation. Elaborative techniques usually take the form of open questions, such as "What does that make you think of?", "Does that remind you of anything?" or "Does anything else about that come to mind?", rather than a bald "Why?", which can be impossible to answer and often serves only to stimulate rationalisation. *Clarification* is a reformulation of something the patient has been saying, reflected back after processing by the analyst; proffering a view that is more coherent but does not challenge in the way confrontation does. *Confrontation* is not necessarily aggressive and it is likely to be most effective if done in a questioning but firm manner, for example, "I get the feeling that there are things that are just too painful to talk about". Finally, *interpretation* usually contains elements of confrontation and challenge by pointing to some anomaly, distortion, inconsistency, or misperception as perceived by the analyst. Whether to be subtle or directly confrontational depends on the state of the relationship with the patient as well as the severity of the underlying problems. The patient who is in danger of acting directly or indirectly in self-destructive ways should be left in no doubt about the analyst's view: "We really need to get to the bottom of why you need to smoke cannabis before coming to your sessions – it is telling us something important, but it is in danger of undermining the chances of change".

Example: A challenging interpretation

A 40-year-old woman whose mother had recently died came to the session and talked of her worries about the rainforests, their destruction by humans, and the devastation of the environment. Knowing that she was someone who often cut herself and had attempted suicide, the analyst acknowledged her environmental concerns, but wondered if she was avoiding her sense of personal devastation following the loss of her mother, not to mention her guilty feelings about sometimes wishing her dead, all of which made her feel like cutting herself down and destroying herself.

Interpretation

Interpretations have many functions, all of which are central to the analytic project. These include enabling the patient to see what he could not see before; to widen his "endopsychic perceptual field" (Rycroft, 1958); to make sense of the incomprehensible; to find meaning where there seemed to be none; to feel things that he could not feel before; and to turn regression into progression.

Interpretation in its simplest form makes something conscious of which the patient was previously unaware or unconscious: "where id was, there ego shall be" (Freud, 1923, p. 80). More correctly, perhaps, interpretation aims to bring to light that which is *pre*conscious. Freud enjoined analysts to pitch their interpretations somewhere between the conscious and obvious and the deeply buried: to interpret only when a patient nearly knows something but cannot quite grasp it.

The Malan/Menninger triangles

While the theoretical aims of interpretation are clear, in practice the form, timing, and species of interpretation are more difficult to define.

A useful rubric is the "two triangles" approach, first described by Menninger (1958) and developed by Malan (1979). The *Triangle of Conflict* consists of Defence, Anxiety and Hidden Feeling. In the example above, the patient's defence was an intellectual preoccupation with the environment (admirable in itself, but not directly relevant to her analysis), distracting her from overwhelming anxiety associated with her hidden feelings of loss and guilt. The *Triangle of Person* or *Triangle of Insight* taps into the subject's relationships with Other(s) (current or recent past), Transference (here-and-now in the session), and Parent (distant past). In the example above, the "other" was the devastated environment, the parent vector was the one who failed to provide the missing sense of safety, and the transference exemplified how one was either *for* her (an accomplice) or *against* her (the devastated one). In neither case was it easy to have a mind of one's own, and this, too, echoed the patient's dilemma.

The triangles are linked, in that the hidden feeling in the Triangle of Conflict may be related to any aspect of the Triangle of Person. Interpretation usually involves a mixture of the two triangles, and the analyst must decide which aspects need taking up at any given moment. A "complete interpretation" involving all aspects of both triangles is rare, and patient and analyst move around them according to the tension within the session.

At the beginning of analysis, the focus may be on the current or recent past because present circumstances are readily accessible, and are likely to have brought the patient to analysis.

Example: Defence–anxiety link

An advertising executive came into analysis complaining that his relationships with women swung from being close and romantic to constantly acrimonious, in which he was accused of being uncaring and cold. His present partner complained that he was becoming more and more distant. He realised that this always occurred at a point when marriage and lifelong commitment loomed. The patient had also changed jobs on many occasions. Each time he appeared to have made a success of his employment, but then would suddenly resign before capitalising fully on his skills. The analyst wondered if the patient had pervasive anxieties about involvement and closeness, and pointed to the parallel between his job changes and his terror of marriage. This simple, but to the patient seemingly unnoticed, link between the presenting problem and other aspects of his life resulted in a deepening of the rapport between patient and analyst, which Malan (1979) sees as evidence for the "correctness" or otherwise of interpretations.

Gradually, the present-day situation is linked to the developmental past, highlighting how anachronistic or unresolved conflicts influence current feelings and behaviour.

Example continued: Bringing hidden feelings to light

The patient began talking about his school friends and whether he had experienced feelings of closeness to them, as well as exploring his parents' relationship. He felt his parents had rarely shown tenderness to each other, but his mother had been particularly affectionate to him. However, she inexplicably left home and travelled around the world for 2 years when he was 7 years old, leaving him with his father. On her return, he remembered her wanting everything to return to normal "as if nothing had happened". He felt somehow different and began to spend a lot of time in his room alone. When she tried to play with him or show affection, he pushed her away. The analyst suggested that he now had to push his girlfriends away to prevent a repetition of the feelings he had experienced towards his mother – a present–past link. The patient recalled how he felt unmoved by her return, almost as if he did not care whether she was there or not. Then, he was flooded with feelings: re-experiencing how close they had been before her sudden departure, and his bewilderment when she was not there. He remembered that he had had no idea why she had left so suddenly, and it was a taboo subject within the family.

As the relationship with the analyst intensifies, the transference–countertransference interaction comes to the fore, quietly at first but with increasing intensity later. All aspects of the Triangle of Person are then available for interpretation.

Example: Triangle of Person: parent–transference link

Soon after this, the analyst told the patient about his holiday dates. As the first break approached, the patient said that everyone but him seemed to be going away, and that his girlfriend was going abroad to work for 2 months. Here was an opportunity, via the theme of abandonment, to link Other (girlfriend), Transference (analyst's holiday), and Parent (mother's abandonment). But intellectual understanding does not equate to cure. Despite the interpretation that the analyst had gained his trust, fostered warm feelings of dependency just like his mother, and then left him, the patient returned after the break feeling detached, cold, and wanting to finish treatment. The analyst compared this with his retreat to his room when his mother had returned from her travels abroad.

While the Triangle of Person is being explored a watchful eye must be kept on the Triangle of Conflict. Interpretation should start from defence, but simply pointing out a defence can feel from the patient's point of view like criticism, as though he is doing something wrong. Defence and anxiety should be interpreted together, preferably with a hint about the hidden feeling.

Example: Back to the Triangle of Conflict

At the same time as linking the patient's response to the break in analysis with his reaction to the return of his mother, the analyst focused on the defensive nature of the patient's aloofness. He suggested that beneath his emotional inaccessibility were painful feelings of abandonment. The patient responded by saying that he did not give a damn what the analyst had been doing or not doing during the break. The analyst stuck to his guns, comparing this with his not wanting to know what his mother had been doing when she went away as a way of not thinking about his emotional pain. Suddenly, the patient revealed that he *was* curious about the analyst's activities, saying in a sarcastic voice, "I suppose you were having a wonderful time with your wife and 2.2 kids". Here was a hint at a

hidden meaning. It turned out that his mother had not really travelled abroad during her absence but, following an extramarital affair, had become pregnant, and had gone to live with her parents. The patient revealed that he had a half-brother about whom he had known nothing. All this emerged only after the transference relationship had intensified to the extent that the patient began to speculate about who the analyst had been with during his holiday. This in turn emboldened the patient to discuss the past openly with his parents.

Diminution of the defence following interpretation may initially lead to an increase in anxiety, which itself will be defended against and need further interpretation, but gradually unconscious feelings come towards the surface through the process of free association. Premature interpretation of hidden meanings should be avoided. It is iatrogenic, leading to either collusive "agreement" or incomprehension on the part of the patient, in both cases decreasing rapport – a state of mind known as *pretend mode* in mentalisation-based treatment (see Chapters 10 and 11). The aim is not to remove defences altogether, but to soften them and help them to become more flexible.

Little by little, the hidden feelings of the Triangle of Conflict begin to link with their origins in the parent–child relationship. A transference interpretation along the lines of "You fear that I will reject you if you disagree, perhaps rather as your father did" implies a one-way connection between present behaviour and past experience. But current neurobiological understanding of memory confirms the psychoanalytic notion of *nachträglichkeit* (see Chapter 3). It is a much more dynamic and two-way process than was formerly conceptualised (Fernyhough, 2013), in which we tell stories about the past in the light of our present experience. Clinically, under the sway of the primary process, past and present converge. The patient's *present* feelings evoked by the analyst may *appear* as though they are emanating from the past. This may account for the phenomenon of "false memory syndrome" (Hayne & Gary, 2006) and is consistent with Spence (1982, 1986) and Schafer's (1983) claim that psychoanalysis is concerned as much with developing a coherent and consistent narrative as it is with "historical truth".

The "mutative interpretation"

Strachey (1934, 1937) considered interpretation within the transference relationship to be *the* tool for effecting change (see Chapter 5). The analyst acts like a new object for the patient, which, together with the *transference interpretation*, creates a new symbolic structure of meaning with which the

patient can approach the world. He gains both new experience *and* insight. Change occurs through identification with the analyst who, rather than behaving like archaic objects adhering to the talion law ("an eye for an eye"), is friendly and available.

At first sight, this seems to contradict Freud's (1919, p. 164) demand that the "patient should be educated to liberate and fulfil his own nature, not to resemble ourselves". A key component of the Strachey model concerns identification. But is it the analyst with whom the patient identifies, as Strachey suggests, the psychoanalytic *function* such as mentalising, a benign rather than punitive analytic relationship (Klauber, 1972), or the analyst as a projected self-object (Kohut, 1977)? There is a movement, in Piagetian terms, from accommodation to assimilation (see Chapter 4), so that the analyst is at first an "external" object, but later his functions become integrated into the patient's personality. Legend has it that Bion's ironic gloss on this was his, possibly apocryphal, statement that there are two possible outcomes to an analysis: the patient either gets better, or decides to train as a therapist!

Lear (2003) has updated the Strachey model, suggesting that analysis puts patients in a "benign bind" (Holmes & Slade, 2018). The therapist fails to conform to the patient's transferential expectations or wishes – is neither as loving nor as rejecting as expected and hoped for – and yet the patient remains held in the therapeutic situation and so cannot escape back to former neurotic ways. The only way forward is psychic reorganisation, in which more complex, nuanced, and "depressive" (in the Kleinian sense) models of self and other can emerge. That way lies health.

Analyst-centred and patient-centred interpretations

The form of the transference interpretation is also important. Steiner (1993, 2011) divides interpretations into those that are analyst centred and those that are patient centred, linking them with the projective systems involved in countertransference. Patient-centred interpretations are concerned with what the analyst imagines is going on in the patient's mind, corresponding with the Triangle of Conflict: "You seemed to dismiss that thought (defence) because you became fearful (anxiety) that it may cause you some pain (hint at the hidden feeling)". Here, the patient gains a feeling of being understood, that someone is able to put himself in his shoes and to be aware of his mental pain.

Analyst-centred interpretations take account of not only what is in the patient's mind but also what the patient thinks is going on in the analyst's mind: "You are afraid that I might become angry with you". Here, the patient learns about the possibility of another mind, separate yet connected, in communication with his own.

Excessive use of either type of interpretation can be problematic. Patient-centred statements downplay the importance of the analytic relationship and unconsciously may be experienced by the patient as an attempt to blame and prematurely return projections. Conversely, analyst-centred comments may lead the patient to feel that the analyst is preoccupied exclusively with him/herself and uninterested in what is going on in the patient's external everyday life.

Non-interpretive interjections

Strachey's concept of the mutative transference interpretation had a powerful effect on psychoanalytic technique. Some analysts concentrate almost exclusively on the relationship with the analyst, and on the current phantasies and the anxieties that their interpretation awakens (Joseph, 1989). Perhaps to redress the balance, there has been a resurgence of interest in more wide-ranging comments outside the analytic relationship itself, especially when a serious impasse (see Chapter 9) has developed (Stewart, 1989).

An example, relevant perhaps to the maverick or ultra-experienced analyst, is Symington (1983) and Coltart's (1986) idea of the "analyst's act of freedom". This is a spontaneous and direct communication, often of anger or exasperation, bringing the patient's attention to the fact of the analyst as a real person rather than as an all-encompassing, all-knowing, all-accepting "breast". Its proponents claim this has a dramatic effect on the progress of an analysis that has become stuck in the doldrums. The element of surprise extricates patient and analyst from mutual imprisonment, and can produce new insight and further development of the therapeutic process. Their case is consistent with O'Shaughnessy's (1992) view that the analytic relationship can indeed become an "overclose enclave" and a substitute for relationships in the outside world. Such spontaneous analytic interjections may break this claustrophobic atmosphere, but equally they could become a self-indulgent excursion, bordering on the wider fringes of Lacanian analysis. As usual, a judicious balance between spontaneity and restraint is likely to be the best policy. As one of our supervisors (M. Pines, personal communication, 1975) said, "When in doubt, don't".

Irrespective of type, accuracy of content, and form, *timing* of interpretation is all-important, as it is in all human interactions, where musical analogies seem particularly apposite. An interpretation should be given at the point of mounting tension, at the moment when affectively charged ideas and associations are firmly attached to the analyst or the analysis, when the atmosphere is ripe, and when the patient almost sees it for himself (Freud, 1940). Such moments arise intuitively, often at the end of a long process of clarification, elaboration, occasional questioning, testing of the transference–countertransference relationship, and confrontation. A good interpretation restores balance, promotes integration, and leads to insight – often to mutual relief.

Insight and working through

Although the concept of *insight* is important in psychoanalysis, there is no agreement as to its exact meaning or its necessity for therapeutic success. The dramatic portrayal of earth-moving insight in Hollywood films is a far cry from everyday therapeutic reality. The cathartic recovery of buried memories happens rarely in comparison with the daily bread and butter of two-steps-forward-one-step-back analytic progress. Acquisition of insight is typically gradual and partial: the patient begins to become aware of his or her own unconscious reality and inner nature and how they affect his or her behaviour, and of hitherto buried unconscious childhood conflicts and their influence on present relationships. It is important to distinguish between cognitive insight and *emotional realisation* (Zilboorg, 1952). Intellectual knowledge on its own is never enough, and may indeed act as a resistance to change.

Etchegoyen (1991) classifies insight as descriptive (i.e., verbal) or "ostensive" (i.e., "shown"). Descriptive insight is a verbal account or story about oneself, often built from associations. In contrast, ostensive insight is a more direct form of knowing, for example, when an individual feels he is in emotional contact with a specific psychological situation that he has known before. Proust's epiphany with the "petites madeleines" would be a prototypical example (Holmes, 2001). Both types of knowledge are integral to the therapeutic process.

Kris (1956b) describes insight in the context of the "good hour" and contrasts it with the "deceptively good hour". In the good hour, the patient starts the session with hostility and pessimism, but at a particular moment something the analyst says lifts the whole atmosphere, and pieces of a jigsaw come together. In contrast, the deceptively good hour starts with an atmosphere of hope and satisfaction. The associations come easily and insight emerges rapidly without obvious arduous work. Under these circumstances, insight merely gratifies either the patient's or the analyst's narcissism. The deceptively good hour often alights on one particular event from childhood – often an abusive one – and uses it tendentiously to account for all subsequent events. The analyst should be alert to this difficult distinction between the defensive use of insight and its positive role in promoting differentiation and autonomy.

In summary, insight integrates unconscious processes with conscious knowledge, links past and present, brings about greater harmony between conflictual wishes, and enables the individual to modify and tolerate previous ways of functioning. Insight is not "given" by the analyst but rather is assimilated by the patient, bit by bit, from the interpretive and non-interpretive elements of the therapeutic process. As the patient reflects on new understanding from different perspectives and from varied aspects of past and present life, an array of emotions is gathered, congruent with these insights – a process named by Freud as *working through*.

In *Remembering, Repeating and Working-Through*, Freud (1914; Phillips, 2016) suggests that patients need time to work through their reluctance to change if they are to feel convinced of the power of their underlying impulses – the very forces they and their analysts are up against! Working through helps to increase self-esteem as patients become aware of the magnitude of the struggle they are confronting, and the effort they are putting in. Working through takes place in the interval between the time the patient becomes aware of something that the analyst has suggested, and the moment at which he accepts it with conviction. It links intellectual (verbal) insight with emotional (ostensive) insight and is triggered by transference interpretations that link intellectual verbalisation to immediate experience in or out of the consulting room. Insight leads to working through, and working through consolidates insight. Through this process, the ramifications of unconscious forces are traced, as far as possible, in all aspects of patients' lives, both within the analysis and outside, and finally lead to the point at which they feel the time has come to leave analysis and venture back into life on their own.

Termination

At first, both patient and analyst may dismiss thoughts of finishing analysis, viewing them as a resistance, but gradually the idea gains credence and is spoken about openly. As a general rule, the topic of finishing should come from the patient rather than the analyst, although there may be exceptional circumstances when analysts need to broach the subject themselves because of personal reasons (illness or retirement), or because they feel the patient will get no further with the treatment, or even because they cannot tolerate the emotional burden aroused by a particular patient. They may then advise the patient on a different form of treatment or suggest another analyst more able to deal with the patient's difficulties.

Theoretical objectives of treatment should not be confused with more common-sense indicators of success. In clinical practice, observable changes occur in patients' lives and in their relationship to the analyst. Most obviously, symptoms decline, family life improves, effective working increases, social relationships are better, sexual life is less conflictual, and anxiety and guilt lessen. A psychic quietening seems to take place, which does not necessarily equate to acceptance of society's norms. People may be helped to divorce or revive their marriage, to change employment, to submit a little in relationships or stand up more often for their own needs, to lose some friendships and gain others. But external changes are not enough. Evidence from within the analysis is also needed.

External changes are corroborated by the analytic process. Patients who talk about how much better their relationship is with their spouse may also report confirmatory dreams. There is more freedom and playfulness of

thought; they are able to negotiate separations such as weekends and breaks more easily without acting out or recourse to excessive use of defensive manoeuvres. Fears of the analyst lessen, allowing for challenge, consideration and thoughtfulness, and acceptance of one's failings alongside strengths. Kleinians will be on the look-out for moves from paranoid to depressive anxieties, while contemporary Freudians hope for replacement of oedipal three-person constellations by more dyadic sexuality.

In the depressive position, a patient becomes aware of his own impulses and phantasies, distinguishes reality from phantasy, recognises his contribution to difficulties, and feels concern for others. Projective mechanisms lessen and become more flexible, and greater trust develops. Parts of the self that have been lost through pathological projective identification are regained (Hinshelwood, 2016; Steiner, 1989, 1993). Rickman (1950) suggests that a point of irreversibility is reached in a successful analysis when all these factors join together and the patient is able to maintain his changes and continue a self-analysis when necessary.

The process of termination has been likened to a "new beginning" (Balint, 1949; Pedder, 2010), weaning (Meltzer, 1967), mourning (Klein, 1950), detachment (Etchegoyen, 1991), and maturation (Payne, 1950; Salberg, 2010). Whichever framework is used, there is general agreement that termination is no easy task for both patient and analyst. Patients struggle for the autonomy that they have so wished for but at the same time experience a continuous regressive pull to comforting patterns of dependence. The analyst's role as container for unregulated feelings and the disparate parts of the self has to be relinquished. At first, these containing functions are internalised by the patient but not fully integrated into the self. Steiner (1993) considers this the first stage of achieving independence. The second stage entails letting go of the object that has been the receptacle of projections, facing its loss, and working through a process of mourning. When things go well, patients are able to acknowledge and feel grateful for the help they have been given, while accepting the loss of ongoing comfort. They will come to accept the limitations of real-world treatment and see a wished-for but unattainable ideal self for what it is. For their part, analysts have to follow the fluctuations between regression and integration, accept their own sadness about ending a significant relationship, mourn the fact that they may never again hear about someone with whom they have become so familiar (Parsons, 2000), and reconcile themselves to areas of failure. Patients may pick up, consciously or unconsciously, on these feelings of failure and attempt to convince their analyst of the great success of the analysis. Patient and analyst have to work together to accept that the analysis was "good enough" and not resort to either to a "mutual admiration society" or the apportionment of blame.

Pedder (2010) dislikes the word "termination", which has connotations of abortion and irreversible finality. He prefers to think in terms of weaning

and Winnicottian gradual disillusionment. A relationship that has developed a high degree of intimacy and importance cannot be discarded easily. Many months or longer may need to elapse between the possibility of termination making itself felt and the actual ending.

Generally, once fixed, the date should be irreversible. If changed, the processes of termination will have to begin all over again with no more surety than they did the first time. In *Analysis Terminable and Interminable*, Freud (1937) pointed out how envy and inability to accept reality may lead to interminable analyses, and that a "lion only springs once".

A specific date must be finalised only after enough work has been done in the final phase of the analysis. Should the analyst alter his technique during this phase? Should, for example, there be a gradual reduction in the frequency of sessions rather than a clean break? More self-revealing equality in the analytic relationship? There are no clear answers to these questions. Some patients seem to like symmetry and if their sessions gradually increased to five times a week, they will attenuate them in a similar pattern; others prefer to work full-time to a date and stop, often at the time of a normal break, say a summer or Christmas holiday. The patient and analyst have to decide these things together and understand their reasons for choosing any particular course. The analyst may "lighten" the transference towards the final few months, answer questions more, and be marginally more open, but his basic analytic approach should not change. Crucial aspects of the patient's psychic functioning may be revealed and will be lost if the analytic task is abandoned before the end.

What about the post-analytic phase? A "clean break" model has much to recommend it. Offers of further sessions may undermine the patient's belief in himself. Once there is a "dissolution of the transference" (Holmes, 2001), both patient and analyst may have fears about maintaining appropriate boundaries in any future relationship. But an absolute ban on further contact is unrealistic, potentially hurtful, and shows little understanding of the vagaries of life. The reality is that some patients do make further contact following termination. Just as young adults need to be able to return to their parents from time to time even after they have officially "left home", so patients in trouble may need to see their former analyst for only a few "top-up" sessions. It should be possible for the patient and analyst to negotiate any future meetings sensitively, without excessive distancing or over-familiarity on either part.

The situation is different for training analyses, which will inevitably mean continuing contact with the analytic world and bumping into one's own analyst from time to time. Analysands may see their former analysts arguing with colleagues, behaving badly on committees, and functioning in other distinctly human ways. Gabbard and Ogden (2009) argue that there will be a prolonged post-training period in which analysts liberate themselves from

the strictures of their training and find their own voice. As they put it, one needs both to honour one's ancestors, and kill the father.

Implicit throughout this chapter is the view that psychoanalysis is a "good thing". We discuss outcome research in psychoanalysis in Chapter 11. Adding to the still-thin corpus of systematic follow-up studies of the long-term effects of psychoanalysis, however methodologically challenging, is urgently needed. The impact on personal stability, autonomy, and the development of meaning structures, maturity, and balance that analysts and analysands feel to be the unquestionable benefits of long-term treatment still remain to be translated into facts that can be grasped by those outside the relatively closed world of psychoanalysis.

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Chapter 9

Clinical dilemmas

> Every beginner in psycho-analysis probably feels alarmed at first at the difficulties in store for him when he comes to interpret the patient's associations and to deal with the reproduction of the repressed. (Freud, 1915, p. 159)

In every analytic session, the analyst is faced with technical dilemmas – when to speak, when to remain silent; when to interpret, when to support; when to direct the patient; and when to help him clarify his thoughts. In this chapter, we shall be concerned with specific issues that may cause particular difficulty when presented to the analyst. We can offer no simple answer to these problems. There is not a unique, correct solution to each problem. Every patient has to be treated according to their particular circumstances. Analysts, in turn, deal with complex clinical situations from experience based on their own analysis, their general clinical and specifically analytic experience, case discussions, and from reading and supervision. As a result, the clinical views expressed in this chapter are inevitably personal and we recognise that many clinicians may practise differently. Nevertheless, we hope that our comments will help newcomers to orient themselves around some of the problems. We hope our comments have general applicability, but it is important to remember that each difficulty has a particular meaning to each individual patient and analyst within the context of the analytic process that has been established between them.

The clinical problems we are concerned with here may be divided into four types (see Table 9.1).

First, there are problems that interfere with the overall *continuity* of the sessions but do not immediately threaten the treatment itself – non-attendance, lateness, breaks, and the so-called "therapeutic impasse". Second, there are *enactments*, defined as non-reflective playing out of behaviours that have unconscious determinants. These may take the form of "acting in" within a session, such as excessive or inappropriate demands, present-giving, problems around fees, and silence on the part of the patient.

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Table 9.1 Classification of clinical problems

Continuity	*Acting in*	*Acting out*	*Special groups*
Absence	Physical contact	Suicide	Adolescents
Lateness	Persistent questions	Self-mutilation	Elderly patients
Breaks	Presents	Drug/alcohol abuse	Patients with eating disorders
Impasse	Money		Training patients
Family	Silence		Patients on medication

Behaviours outside the session or "acting out", defined as those that have unconscious determinants related to current treatment, present the most serious technical challenge to the analyst and may threaten the treatment itself. These typically can take the form of self-injurious actions such as suicide attempts, self-mutilation, and drug abuse. Finally, there are *groups* of patients that present their own sets of challenges – for example, adolescents, patients with borderline personality disorder (BPD), patients who have experienced severe childhood trauma and show current trauma symptoms, patients on psychotropic medication, those with eating disorders, candidates in psychotherapeutic or analytic training, members of ethnic minority groups, those experiencing gender dysphoria, and people who have had a previous analysis.

It is not our intention to cover all these examples, but rather to illustrate how to approach some of the clinical issues that they raise. Inevitably, problems are often linked. The patient who is chaotic in their life is also likely to be disorganised within the framework of analytic sessions; someone who arrives late may also fail to pay bills on time; the patient who makes excessive demands may also threaten suicide; and so on.

Problems concerning the analytic process

Difficulties that interfere with the process of analysis are grist to the mill in all analyses. In general, they are examples of resistance (see Chapter 1) and will always need to be addressed if an analysis is to progress. The process of mental resistance in a clinical context is best considered as an adaptive mental process that is protective, maintaining the stability of mental function, and thereby interfering with change. It is not simply disagreeing with the analyst! Freud (1937) recognised in *Analysis Terminable and Interminable* that defences, when mobilised in treatment to manage former dangers, create impasse and militate against recovery. Resistances have unconscious ramifications depending on the patient's particular dynamic constellation and the state of the analytic relationship at that moment. The analyst and patient gradually understand that an event, such as lateness or "forgetting" to pay a bill, a demand, or a feeling, has specific meaning at a particular

time, related to their relationship and its representation of the past. However, the same experience may be understood differently later, as their relationship changes and deepens. Any event or symptom is "over-determined", with each having its own coherence at a particular level of interpretation (Breuer & Freud, 1893–1895).

Lateness

Lateness for a session is often associated with resistances within a session such as repetitive material, avoidance of painful topics, reporting of trivial daily events, and silence. Sometimes, the patient is consciously aware that the reason for his lateness is that he does not wish to talk about something. More often, he finds himself arriving late for a variety of apparently unavoidable external reasons. Apologies are given and the session continues normally. The analyst needs to make a mental note of the lateness and listen carefully. There is usually no point in trying to address the lateness straight away. There will not be enough supporting evidence for interpretation. Questions are likely to divert the session away from spontaneous material, and attempts to take up the unconscious motivation behind the lateness too soon will lead to rebuttal and repetition of the rationale for the late arrival. It is best to wait.

Example: The stalling architect

An architect, arriving 15 minutes late for his session, explained that his car would not start and then kept stalling. He apologised. The analyst accepted his explanation without comment but noted that it was unusual for his patient to be so late. The patient continued to apologise, saying that he had wanted to be on time as he felt the session the day before was important. He could not remember what the session had been about but he had felt upset by it. The session then became punctuated by hesitancy and silence – it did not seem to start properly and "kept on stalling". As a result of the hesitancy in the session, the silence, and the patient's inability to remember the previous session, which had been about his increasing feelings of dependency, the analyst suggested that the patient was in fact reluctant to come because of anxiety about his reliance on the analysis. The patient then talked about how he had rather hoped that the car would stop altogether and that he would be forced to miss the session. Further work suggested that the patient was thinking about stopping his analysis, which he felt was demeaning, fearing that he would become addicted to it.

Some patients are persistently late, often by the same number of minutes each day, and others are rigidly early or on time, showing little flexibility in the regime they set themselves. The reason behind their rigidity is often defensive in nature, aimed at avoiding painful feelings.

Example: Controlling time

A 19-year-old student was 10 minutes late for every session from the start of analysis. He never mentioned it and seemed unperturbed. His father was a dominating man who was rather rigid and obsessional. There had been no period of adolescent rebellion and the patient was successfully completing a university course. Whenever the analyst mentioned the patient's lateness, he shrugged and said nothing further. The analyst decided to leave the persistent lateness in the background for a number of months. During one session, the analyst had himself been delayed. The patient, arriving at his usual time of 10 minutes late, had seen the analyst hurrying back to the consulting room. The analyst apologised but the patient became increasingly angry and talked about how the analyst had ruined the treatment. He said he expected the analyst to be sitting in the consulting room waiting for him to arrive at the start of the session: it was not up to the analyst to dictate when the session was going to start; it was his prerogative. Further work showed that the patient's phantasy was of being omnipotently in control of both the session and the analyst. This phantasy had been punctured by the analyst's late arrival. The patient was behaving towards the analyst very much as his father had treated him. If the family was going out, his father would insist that he and his brother were ready and waiting, lined up by the front door at a prearranged time. His father would then slowly gather his things together before inspecting them. This important theme was contained but concealed in the lateness, and emerged only in response to a slight rupture in the analytic frame – a not uncommon phenomenon.

These clinical vignettes show the importance of waiting before trying to understand the meaning of interferences with the analytic process. This is in accordance with Freud's recommendation of interpreting when an unconscious idea is just below the surface – neither so deep that the patient will not understand nor so near consciousness that the patient can work it out for himself. Resistance occurs at a point of psychological conflict and therefore represents a potential focus of change. A resistance, such as persistent lateness or abject punctuality, needs to become uncomfortable to the patient before its analysis can be effectively accomplished. The architect felt

perturbed about his lateness and apologised. As a result, it was possible to interpret his lateness in the immediacy of the session. In contrast, the student was apparently unperturbed by his unpunctuality, and it became available for analysis only when threatened by the analyst's lateness.

Breaks

Breaks in treatment at weekends, for holidays, or because of unavoidable commitments on the part of either the analyst or the patient are an inherent interference with the analytic process. But, once again, they offer an opportunity for change as a result of the feelings they stir up. Some patients react to a weekend or holiday with relief and celebration. For them, analysis is in some way a chore, a requirement, and they struggle under feelings of oppression. In their mind, perhaps the analyst is a critical superego figure, always ready to comment adversely on their behaviour and fantasies. Weekends and breaks become a welcome freedom. Friday sessions may be marked by a sense of relief and excitement, while Monday sessions are full of foreboding, despondency, and guilt about the uninhibited activities of the weekend.

Others experience the weekend or holidays as abandonment. One patient secretly tape-recorded Friday sessions, playing them back to herself throughout the weekend. Another would reluctantly tear herself away from the Friday session and go to bed for the whole weekend, able to come alive again only on Monday morning. For some, the break symbolises primitive feelings of being dropped and falling for ever; in others it will stimulate feelings associated with an early oedipal situation, representing imagined exclusion from the parental relationship.

Example: A needy intrusion

One Friday, a patient protested that he would feel better if he knew what the analyst was doing over the weekend. At the weekend, he "found himself" passing the analyst's consulting room and looking at his house to see who was there. On Sunday evening, he phoned to check that his Monday session was at the usual time. On Monday, he was sad and depressed as a result of his feeling of exclusion, and guilty and ashamed about his intrusion.

His father had left home when he was 4 years old. From that time, he slept in his mother's bed until he was 12. For many years, this gave him a feeling of security and safety. The chance to negotiate a positive oedipal transition from exclusion to a sense of a life and mind of his own had been denied him, and was now being played out – and potentially remediated – in the transference.

Patterns emerge over weeks and months. Only after they become clear can the analyst begin to address them. Reactions vary according to the transference relationship at the time. Patients in a severely regressed state or in a "malignant regression" (see Chapter 8) may refuse to leave the consulting room, which may in the end jeopardise treatment. In less severe cases, a reality-based statement can help, such as, "You will have to leave now as I must continue with my working day. When I have finished I shall contact you and we will decide what to do". The analyst has to assess the patient's capacity to manage over a break or weekend, and may need to recruit another mental health worker or the patient's general medical practitioner. In general, it is best to anticipate such difficulties and to make appropriate arrangements well in advance, as well as always considering the unconscious meaning of such extra-analytic actions (Stewart, 1977).

Some analysts send their patients a postcard or write a brief letter during a long break. This may help borderline patients, whose fragile hold on reality can be threatened by the prolonged absence of the analyst. The postcard reinforces the patient's recognition that the analyst keeps him in mind even when he is not there. However, it may also provoke envy, resentment, and hostility, especially if sent from an exotic location. The analyst should hold the postcard or letter in mind when the sessions resume, and listen out for its impact on the patient.

Example: Human contact

A patient with BPD, feeling terribly frightened by a forthcoming month-long break, complained of being abandoned and uncared for. She experienced her analyst as sending her away, never to return. In her associations, she remembered a time when her mother had gone off to hospital to give birth to her younger brother and she had to stay with an aunt for a month. Initially, she protested, but after a few weeks of being away she no longer felt the need for her mother. She expected the same to occur with the analyst's absence. When he sent her a postcard during the vacation, she was amazed that he should understand how bad she felt, and the therapeutic alliance was strengthened.

Another technical problem is the timing and dosage of interpretations before breaks. Patients may gradually withdraw just before a long break to protect themselves from uncovering painful experiences with which they will be left to struggle on their own for a number of weeks. The analyst should respect this and weigh up how much distress the patient can bear. The analyst has also to deal with his own countertransference reactions to

weekends and breaks. Many analysts take on more work than is sensible. Fridays come as a relief, Mondays as a chore, and holidays a release from exhaustion. Analysis is difficult enough without being subjected to such conditions, which may, if unanalysed in supervision, be responsible for a therapeutic impasse.

Impasse

The term "impasse" is used to denote a state in which the analysis neither progresses nor retreats. The setting itself is not noticeably changed, the patient continues to talk, apparently free-associating, the analyst interprets, but nothing much changes or develops. This process is recognised as "pretend mode" mental functioning in mentalisation-based treatment. Unsurprisingly, impasse due to pretend mode mediates poor outcomes of treatment in any therapy (Sharp & Vanwoerden, 2015). The patient and analyst go around in circles in an "as if" analysis. It is tempting either to see an impasse as arising out of the patient's resistance or to consider it as a technical fault on the part of the analyst. However, an impasse is best seen as a joint problem to which both patient and analyst contribute. Both find themselves bound up in a tangled knot created by the patient's psychopathology and the analyst's countertransference. From an intersubjective perspective, the analyst's comments and theories are no longer reciprocal to the patient's feelings and distort the subjective meaning of their experience (Aron, 2006). For Kleinian analysts, there is a retreat from the depressive position to paranoid–schizoid function and failure to generate a third perspective at an oedipal level. Rosenfeld (1987) ascribes most blockages in the patient–analyst interaction as being due to the analyst's unconscious infantile anxieties. To avoid becoming aware of these areas, the analyst colludes with a complementary part of the patient's personality. In all cases of deadlock, therefore, analysts have to examine their own feelings very carefully and look for hints of collusion or mutual resistances that afflict both themselves and their patients.

It is important to distinguish an impasse from a negative therapeutic reaction (see Chapter 8) that follows a period of progress. A true impasse develops slowly, almost imperceptibly, and is recognised only when the analysis remains static or the patient seems immutably fixed in a particular frame of mind. By contrast, hostility, often in the guise of manic defences or manic attacks (Rosenfeld, 1975), usually underlies a negative therapeutic reaction and may appropriately be taken up as envy of and triumph over the analyst. In an impasse, hostility is conspicuously absent and manic defences are not apparent. Interpreting hostility will be incomprehensible to the patient, as well as unfair, since the analyst's reactions are involved as well (Rosenfeld, 1987).

Meltzer (1967) describes a common impasse, which develops when a patient is on the verge of moving into the depressive position and the end of treatment is in sight. At this point, patients take responsibility for their guilt and badness but, rather than experiencing feelings of remorse and feeling able to face independence, they remain static, preferring to use the analyst as a permanent prop. Equally, an impasse based on "reversible perspective" (Bion, 1963) may be so subtle as to be undetected. Reversible perspective refers to the situation where there is manifest agreement between patient and analyst but a latent contradictory agenda, for example, of disagreement, hostility, or emotional disengagement. The patient might seem to come for one purpose – to "get better" – but in reality has a covert agenda, for example, to placate a partner, make social contact, or as part of a career plan in psychiatry or psychotherapy.

What should the analyst do in these situations? Conventional interpretation has been shown to be ineffective. Sometimes, it may help to alter the setting for a short time – for example, by asking the patient to sit up – while the impasse is discussed openly and the patient's criticisms are listened to. It is important not to interpret but to listen carefully and even answer the patient's questions directly. In the case of the "Wolf Man", Freud (1918) took more drastic action, setting a definite end point to the analysis. Inevitably, such a decision during an impasse is complicated by countertransference, and such a move is probably best done only after discussion with a colleague. Supervision is essential in this situation.

O'Shaughnessy (1992) suggests accepting the patient's psychic reality rather than trying to challenge it, particularly if the impasse is a battle lodged in the transference–countertransference relationship in which the analyst is equally trapped within the impasse. The analyst has to make a shift in themselves. Their task is neither to accept nor oppose the area of impasse, but to recognise the patient's position. This will, if it goes well, allow them to internalise a more accommodating superego. Only then can the patient begin to address the impasse.

Enactment: acting in

Clearly, many of the situations discussed in the previous section present the analyst with problems within the session, but not as immediately as sudden demands, financial matters, present-giving, and continuing silence. Once again, the primary grist-to-the-mill rule applies. All events must be considered within the patient–analyst relationship, giving special consideration to transference and countertransference.

Physical contact

Making physical contact with a patient is traditionally a taboo in psychoanalysis, partly because touch is often equated to sexual skin contact. But

hugging, soothing, and stroking – sexual as they of course are – can also be manifestations of non-sexual attachment and friendship. The discussion has become more nuanced over time (Orbach, 2003). Balint (1968) suggested that holding the patient's hand can in special circumstances be a helpful first step to a "new beginning", and overcome a "basic fault". Pedder (2010) similarly argued that bonding between a security-seeking person and an attachment figure can be protective rather than sexual, and therefore that hand-holding is not inherently seductive.

In a more benign manner, patients may make physical contact ostensibly as part of a normal social interaction process, for example, shaking hands at the beginning and ending of a session. This may be culturally appropriate and accepted by both patient and analyst. On other occasions, physical contact may be more extreme, with the analyst forced to make physical contact to restrain a patient (Stewart, 1992) who sees nothing untoward in his or her expression of need and demand for gratification. A patient with an erotised transference (see Chapter 5) may be unperturbed by their analyst's refusal of tenacious demands for sexual gratification. Because of blurring of internal and external reality, the expectation of sexual consummation with the analyst is experienced as reasonable, desirable, and, above all, achievable. If the analyst deviates from the rule of abstinence in this context, even in an attempt to create a more "holding" environment, the outcome is likely to be disastrous (see "Too close, too soon" in Chapter 10). The task of the analyst is to help the patient first to recognise the inappropriateness of the demands and second to reflect on their underlying motivation – a move from "ego-syntonic" demand for gratification, in which there is no obvious anxiety, to an "ego-dystonic" state, in which anxiety and conflict over the desires come to the surface. Although some demands for touching or holding are obviously inappropriate and part of an erotised transference, others, such as looking for reassurance and compassion from the analyst, appear more reasonable but may represent a subtle denial of aggression or of the "virtual" nature of the analytic relationship.

Careful scrutiny of countertransference and vigilant listening to the desires, fears, and traumata that lie behind the patient's request open the opportunity for a mutative, albeit painful, experience for both patient and analyst. Every demand for contact needs to be considered in this way. Technically, the analyst must ask himself "What role am I being asked to play for this patient at this particular time, and why?". Winnicott (1958) suggests that a common reason for such a demand is the need of the patient to experience in the present – that is, within the relationship with the analyst – those extreme feelings that belonged to earlier traumatic experiences that were frozen in time because they had been overwhelming for the primitive ego. Casement (1985) argues that analysis enables such traumata to be "brought within the area of omnipotence". His refusal to hold a patient's hand – after carefully considering the question and so signalling to her that he took it seriously – brought back for

the first time a terrifying memory of her mother fainting just at the moment when she was being anaesthetised following a painful scalding at the age of 2, an injury that had deformed her self-image ever since. Following the re-enactment, the patient improved dramatically, in a way that could not have happened had he merely offered her the support she was demanding. In a later discussion of the case, Casement (2002) argues that acceding to the patient's request for touch would have been easy; the hard part was inhibiting his desire to touch. The situation was managed therapeutically through work on his own countertransference responsiveness.

The patient's family

Patients who create severe difficulties within treatment are also likely to have caused problems to other professionals and with their own families. In the "basic model" technique of psychoanalysis, relatives are a neglected group, often distanced from the treatment to protect the therapeutic alliance and the privacy and intimacy of the relationship between patient and analyst. They are viewed as a source of danger, contaminating the "aseptic field". Freud (1912) – within the claustrophobic community of early 20th-century Vienna not immune to extra-therapeutic contacts – confessed himself "utterly at a loss" to know how to treat patients' relatives. However, their lives are inevitably influenced by the patient's analysis, and it is natural for them to worry, take an interest, and be affected if the patient changes. It is important to distinguish between whether relatives' involvement arises from the patient himself, the relatives' own anxieties, the analyst's worries, or a mixture of all three.

Unconscious processes of spouses may have a marked influence on the outcome of treatment.

Example: An involved husband

A married patient with BPD relied on her husband to stop her from cutting herself and taking overdoses. She had to report to him at preassigned times if she was out, he dispensed her medication on a daily basis, and he regularly searched her handbag to remove razor blades. If she failed to phone him at a prearranged time, or if he found razor blades in her bag, he punished her by withdrawing some of her financial allowance. On many occasions, he physically restrained her from lacerating her arms. During the patient's analysis, it became clear that she and her husband were engaged in a subtle struggle disguised as caring support. As the analyst and patient began to address this issue, the husband insisted that he would no longer pay for the patient's treatment. By this time, the therapeutic relationship was

strong enough to allow the patient to challenge her husband's threat. Marital conflict was inevitable. The patient's husband requested a meeting with the analyst and, after asking the patient's permission, the therapist agreed. In discussion, it was decided that the patient should continue in analysis while they jointly saw a marital therapist. Although this was an unusual course, it saved the treatment.

In more recent years, psychoanalysts have used modified techniques to treat patients with borderline and narcissistic personalities. A large number of these patients are suicidal or self-destructive and/or may have drug and alcohol problems. Serious acting out may occur. In these circumstances, relatives can be allies. It is often helpful to see a spouse or partner at the initial interview to discuss the treatment. If a formal contract is set up, as may be helpful for patients with BPD (see Chapter 10), it is important that both patient and relative(s) agree with it and understand how it operates. If difficulties are not foreseen, the analyst may be forced to contact relatives in an emergency, overruling the normal practice of not doing so without the patient's permission. However, analysts need to think carefully about what to tell the relatives, to protect the therapeutic relationship. All this is best discussed with the patient beforehand. Alternatively, the patient should be present at all meetings involving the relatives. This minimises the risk of information becoming distorted or used inappropriately within the family, but increases the danger of analysts basing treatment on what they perceive as an objective reality, rather than manifestations of transference.

Example: Too much protection

A 36-year-old man had become seriously depressed and suicidal, although not to the extent of requiring hospital admission. One morning, he left the house without saying anything and did not return as normal for lunch. His wife and brother were worried, and so phoned the analyst to see if he had been to his session that morning. The analyst refused to answer, saying that she would need the patient's permission. Inevitably, the patient's wife and brother were infuriated and drove to the analyst's house to confront her. On reflection, the analyst felt she was shutting out the relatives in the same way as the patient had shut out his family by walking out without saying anything. She then arranged a meeting between them all and took up the patient's withdrawal and the reasons for creating such anxiety about suicide in his wife and relatives.

Occasionally, a patient may bring a relative unannounced to a session.

Example: A heated meeting

A patient who had been in analysis for 2 years arrived at a session together with his wife. He told the analyst that his wife had asked to come but his wife contradicted this, saying that he had asked *her* to come. They had had a row the night before and the patient wanted the analyst to adjudicate. The analyst said he would agree to see them together briefly and answer any questions they may have, but in future such meetings should be prearranged. In the ensuing discussion, the husband and wife started to argue again, with the patient threatening to hit his wife. The analyst stopped the session and pointed out to his patient that he seemed to want to show him how angry and out of control he could become. The patient's wife responded immediately by saying that she had always felt the analyst did not know the severity of the patient's difficulties and what she had to put up with.

This vignette illustrates the ambivalence inherent in such situations. For the patient, it was an attempt to avoid working through his aggression. His conflicts were being acted out with his wife rather than contained within the analysis. For his wife, it was to allay her anxieties that the analyst was encouraging the patient's threatening behaviour, and a healthy wish, perhaps unconsciously driven by her husband, to bring his uncontrollable behaviour into the transference and out of the marriage.

Involvement of relatives has always been openly accepted in the analysis of children and adolescents. It is commonplace for parents to be seen at intervals by child analysts, while maintaining the confidentiality of session material, or to be offered help in their own right. Nevertheless, in adult analysis, too great an involvement of family members may be related to anxieties in the analyst and can detract from enduring and working through conflicts that are central to the patient and to analytic progress. This is particularly likely to happen when patients are suicidal and anxieties are therefore at a maximum.

Example: A secret pact

A patient with BPD, working as a dental nurse, had always harboured thoughts of suicide as a solution to her problems. Prior to her marriage she had tried to kill herself by injecting a cocktail of drugs and jumping from a building. She had never told her husband about

this, and he was unaware of the seriousness of her plight and of her persistent suicidal thoughts. But when her suicidal thoughts became compulsive, just before a break in her treatment, the analyst decided that he must talk to her husband. After asking the patient's permission, the analyst invited her husband to a meeting. As a result of the relief that her secret past was now revealed, the patient's suicidal thoughts receded, but returned some months later, just before the next holiday. Once again, the analyst considered talking to her husband but was now more circumspect, realising that this was not really getting to grips with the problem. He broached the subject with the patient, who, this time, refused permission. The analyst became aware that he wanted to tell the patient's husband of the return of the suicide risk only to protect himself from criticism if she did in fact kill herself, and because he needed someone else's support in the treatment. The patient's refusal was an implicit statement that the patient and analyst needed to deal with the problem within their relationship. However, the analyst requested supervision from a senior colleague to help him tolerate his worries about the patient's possible suicide. This enabled him to address the thoughts and feelings of suicide with the patient, who found them equally intolerable.

Again, this illustrates how the use of the analyst's countertransference, clarified in supervision, may lead to the most effective way of intervening in complex clinical circumstances. The previous solution of talking to the husband had, in fact, been an unconscious attempt by the patient, in collusion with the analyst, to undermine or even "kill off" the analysis itself, which had engendered feelings of dependency and rage in the patient. Further analysis enabled this to be linked to the tendency of the patient's parents to bring in outside help during her childhood whenever she had a problem. The patient had experienced this as a sign that they did not love her enough to help her themselves, and that when she felt she needed them most they were likely to abandon her.

Psychoanalysts may have to work as part of an intervention system within which a patient is offered a range of interventions. For example, when treating a patient on probation for domestic violence, the analyst will require clarity about what might be reported to the partner, what would have to be reported to the patient's probation officer, who is responsible, and, for example, whether a simultaneous anger management course and domestic violence intervention would conflict with or support the analytic treatment. This is best discussed between all parties in a case conference format at the beginning of treatment to ensure the analytic process is facilitated rather than hindered by interactions between agencies offering multisystemic

interventions. Circumstances that would trigger contact between professionals can be defined with the patient at the outset rather than being cobbled together in haste during a crisis.

Enactment: acting out

Freud first used the term "*agieren*", later translated as "acting out", in his discussion of his treatment of Dora: "by breaking off her analysis Dora '*acted out*' an essential part of her recollections and phantasies instead of reproducing them in the treatment" (Freud, 1905, p. 118). He continued to use it in a more restricted sense, referring to those acts or series of acts that are a substitute for remembering and repeating – "the patient acts it out before us, as it were, instead of reporting it to us" (Freud, 1940, p. 175). It is one of a number of psychoanalytic concepts that has shown considerable elasticity over time and has become an over-inclusive term, often encompassing all behaviours of which the analyst disapproves as well as actions, such as recurrent destructive acts, that form part of an individual's impulsive character or personality. Thus, acting out, also characterised as "enactment", has become a ubiquitous and continuous process in analysis, leading to suggestions that a review of the concept is overdue (Bohleber et al., 2013).

Acts within the session, such as walking around the room, hitting the wall, pushing books off the shelves, or actualisation in the transference, have been known as "acting in" (as described earlier in this chapter). But distinguishing phenomena on the basis of where they occur is hardly illuminating. Behaviours within and outside the analytic encounter may have similar psychic determinants. As Freud stated: "Playing with one's watch-chain, fingering one's beard…jingling coins in one's pocket…fiddling with one's clothing in all kinds of ways…regularly conceals a sense and meaning which are denied any other form of expression" (Freud, 1901, p. 194). This is regardless of the location where the action occurs. What matters is the context, especially the interpersonal context.

Acting out implies a regression to a pre-reflective, pre-verbal level, a belief in the magical effects of action, and a desperate need to get a response from the external world, often in the context of an internal existential crisis. Chused (2003) makes the case that enactment may occur without a major change in behaviour and may be considered as happening when the patient's verbal expressions stimulate unconscious conflict within the analyst – for example, sleepiness or rage – leading to an interaction that has unconscious meaning for both parties. A similar view is that it has a communicative function arising from unprocessed mental material begging for symbolisation (Di Ceglie, 2013). Others see enactments and acting out as manifestations of "wild transference" or as arising through co-production via the analyst's unconscious expression of countertransference (Streeck, 1999). Thus, analysts might vicariously enjoy their patient's misbehaviour, just as

"buttoned-up" parents may tacitly condone rebellious behaviour in their children. The role of countertransferential influence should be considered if acting out escalates despite careful interpretation and, as always, supervision is essential to help the analyst extricate himself from anti-therapeutic involvement. The psychoanalytic setting itself could be seen to encourage acting out by inducing regressive behaviour. Maturity implies integration of action, sublimation, symbolisation, and other "higher" integrative mental functions. The dis-integration associated with regression is particularly marked in patients with borderline and narcissistic personalities (see Chapter 10). For these patients, actions speak louder than words, create a more immediate release of tension and frustration, have greater potential for influencing the analyst than continual dialogue, and often give a spurious sense of control. However, acting out will occur in every analysis. It is impossible for all aspects of experience, especially certain affects and sensations, to be expressed in words – as all who have been in love can testify. The task of the analyst is to ensure that enactments are a stimulus to the analysis rather than an interference.

Acting out has both positive and negative aspects, the latter often resulting from the consequences of the action rather than from the act itself. On the positive side, the act may be a communication that becomes a useful source of analytic material (Skogstad, 2015). Balint (1968) famously described a patient who enacted a somersault in her session – something she had previously thought she was incapable of – ushering in a breakthrough in her analysis. On the negative side, it can be destructive, personally dangerous, or even life-threatening, and may jeopardise the analysis; the unconscious internal drama or phantasy passes directly into "real life", circumventing thought and psychological defence. Often, close analysis of an episode of acting out will reveal important details of an unconscious conflict.

Example: A problem of expression

A 29-year-old man began psychoanalytic treatment because of sexual anxieties, concerns about his appearance, and difficulty in getting close to people. He had experienced his mother as a dominating, overly organising woman who was so obsessed with cleanliness that she had given him regular enemas as a small boy. As treatment progressed, he became more confident and found himself a girlfriend. Just as they were planning to buy a flat together, he began to demand that the analyst reassure him about the move. The analyst tried to interpret his fears of intimacy but failed to appreciate the concreteness of his patient's fears. Immediately after a session, the patient took an overdose and cut his abdomen, blaming the analyst for not helping.

This act was later understood as a communication that he was terrified that his girlfriend would dominate and control him and his "insides" just as his mother had done, and that his father (analyst) would abandon him to his fate. His body represented the part of him that he felt his mother had abused, and he now had to resort to overdose and self-laceration to show the analyst the terrifying nature of his phantasies and demonstrate his need. Following this event, the analyst and patient focused on the patient's serious fears that the analyst would stop seeing him. Such an event did not occur again, and the patient gradually settled with his girlfriend.

Destructive acts such as this often have an electrifying effect on analysts, especially when they are unexpected, and will inevitably induce complementary countertransferential responses. Analysts may apply "rules and regulations", sometimes out of panic. These in turn may lead to an escalation rather than a diminution of the self-destructive acts, especially if unaccompanied by understanding. Interpretation is the vehicle through which acting out is best challenged. The example given above illustrates the different issues that need to be considered when there is serious acting out. Is there a failure of containment; a problem in recognising something that is currently unrecognisable and unconscious; of not talking about something that is split off or projected and too painful for both patient and analyst to address; or is the action related to what is being talked about and not managed (Steiner, 2006)? If the assessment interview suggests that serious acting out is likely to be a feature of analysis, the analyst, as already suggested, needs to draw up a contract with the patient at the beginning of treatment and not wait until something untoward occurs. Appropriate support, set up before treatment, can be activated while the analysis continues.

Suicide

The threat of suicide poses the most immediate challenge to the analyst. He must assess the intensity of the threat and formulate a clear plan within a short space of time. This means gauging accurately the depth of the patient's despair, the level of hopelessness, the seriousness of plans, the degree of external support, as well as the contribution of exacerbating factors such as increasing use of alcohol or drugs. If there is no doubt about the seriousness of the threat, the analyst must act decisively, tell the relatives and other carers, and – against the patient's will if necessary – arrange hospital admission himself or through a third party such as a general medical practitioner or social worker. The effect this has on the viability of the analytic

relationship can be dealt with later. In many cases, the decisive action of the analyst may be beneficial to the analytic process, which may have laboured for too long, or even been immobilised, under a constant threat of death.

Thoughts and threats of suicide can also become part of a patient's way of life. In these cases, the analyst may tell the family that the patient is chronically suicidal and has a definite risk of death, and express his willingness to enter into treatment of the patient but give no guarantee of success. Realistic appraisal with relatives early in treatment, or even before treatment starts, will help to prevent their countertherapeutic involvement, and protects the analysis from the patient's attempts to control the therapy by inducing fear of third parties and guilt about failure.

In order not to overreact to the threat of suicide, the analyst needs to hold in mind the affective constellations – hopelessness, rage, and guilt – that are commonly experienced by suicidal patients. These represent, respectively, the wish to die, the self-directed wish to kill, and the wish to be killed. Hopelessness may infuse the analysis to such an extent that the analyst himself becomes "infected". It is at these times that suicide becomes more likely. The analytic relationship should always contain some hope, even if it has to be carried by the analyst alone for a time. Rage and the self-directed wish to kill may be easier to deal with. The suicidal threats are ways of attacking, coercing, dominating, manipulating, and controlling the analyst as well as the outside world. The underlying phantasy may be that of killing oneself to make someone else suffer and at last recognise one's importance or need. It is particularly important to understand who the analyst unconsciously represents in the patient's mind, and who is therefore the unconscious subject of the attack. Freud (1917) suggested that suicide becomes possible only if an individual becomes fully identified with a lost object. At this point, self and object become fused. In phantasy, the attack is on the abandoning object rather than the self, and killing oneself is equivalent to murdering the abandoning object who is causing so much pain.

Example: Hopelessness, rage, and guilt

A patient with BPD felt that her life's task was to look after her mother. Her analysis had been dominated by attempts to control her analyst, demanding session changes, phoning out of hours, and seeking sessions at weekends. When her mother suddenly died, she became angry and bitter, denigrating herself and saying that she had achieved nothing. Without her mother she had no clear reason to live. She described herself as someone "who nobody could see" and said that if she were dead there would be only a "slight ripple in the world, which would be covered over in an instant". Her analyst suggested that she felt he, too, would not notice that she had gone and would

simply replace her with someone else. She then reported that she had begun to plan her suicide, fuelled by increasingly horrible thoughts about her dead mother. Her analyst tried to persuade her to go into hospital, but initially she refused. She reported a dream in which she was sitting at a window looking in from the outside. At first, she saw her mother through the glass, and then suddenly they were both together on the inside. At that point she and her mother became one person. In the dream the patient then banged her head on the window to try to get out, but this only resulted in her smashing up her face, her brains oozing out, and blood gushing everywhere. Someone watched this scene without intervening and then walked up and led her away. She felt relief.

Her analyst interpreted the rage she felt towards her mother, who had left her with no role, and how she found herself wanting to join her mother but at the same time wanting to escape from her. Escape led to her destruction (the smashing of her head against the window), an inability to think (her brains oozing out), as well as a feeling of guilt. The analyst-figure meanwhile merely sat near and watched. During the session her analyst insisted, and the patient agreed, that she should go into hospital. He made it clear that he could not and would not watch her trying to kill herself.

In this vignette, hopelessness is suggested by the patient's sense that her own death would only make a ripple. She tried to dominate the analyst and mould him to behave in the same way as she felt her mother did to her. At the point of her mother's death, she attacked herself in a way that she wished, unconsciously, to attack her mother. The patient was identified with her mother, as illustrated by the dream. Suicide meant attacking the mother with whom she was identified, but the dream also suggested that it was, in phantasy, a way of differentiating herself from her mother. In the transference the analyst was a passive father who allowed her to remain controlled by her mother.

Analysis of "attacks" on the analyst may lead to severe feelings of guilt as patients begin to recognise their own part in their difficulties. This move to the depressive position (Klein, 1952) is heralded by a realisation that the analyst has, and always has had, something useful to offer, which has previously been denied or treated with contempt. When this is linked to important figures in patients' past they may become overwhelmed with guilt, believing they have destroyed those whom they unknowingly loved. The need for punishment becomes so severe as to become a wish to be killed by those whom they have harmed. Suicide becomes the only way of satisfying them. A sense of helplessness may also arise as patients feel at the mercy of

internal and external events over which they have no control. This is another twist in the risk of suicide, which by turning passive into active becomes an action to relieve the anxiety of helplessness by being in control – to kill before being killed (Laufer & Laufer, 1989).

It is tempting to translate these three constellations into technical strategies – hopelessness to a counter-response in the analyst of making affirming statements, rage to limit-setting and active interventions, and guilt to facilitation of mourning and supportive work. However, things are rarely this simple. But holding the three leitmotifs in mind allows the analyst to empathise with the patient's desire to die, to understand the excitement of suicidal phantasies as release from mental pain, to recognise the exhilarating sense of power they unleash, and never to underestimate their destructiveness.

Special groups

Analysis in adolescence

Many of the problems discussed earlier in this chapter are more common in the treatment of seriously disordered adolescents and young adults (see Chapter 3), especially acting out and the need to involve relatives. Adolescence is a time of developing independence. Sexual identity begins to become established. There is intense preoccupation with appearance and change in body image, an exploration of the balance between intimacy and individuation, grappling with fears of merging on the one hand and isolation on the other. Adolescents are emerging men and women of action as they struggle to understand and renegotiate their relationship with the world in the context of their developing social, physical, and sexual powers and frailties. They are wary of adults, although desperate for new figures with whom to identify. Their internal world is in a state of flux. Internal conflicts tend to be externalised, impulses difficult to control, and feelings dangerous to express. Phantasies can be only partially sublimated. Impulsivity, bewildering sexual feelings, and outbursts of anger and emotion result.

All this affects the analytic process and requires technical agility on the part of the analyst, particularly at the beginning of treatment. Adolescents who enter treatment of their own accord usually feel that they have failed in their attempt to rework their psychological world, hitherto based on childhood relationships and identifications. A sense of self-loathing and despair may prevail. At first, it is best to listen and not to interpret. Transference interpretations evoke infantile relationships at the very moment when the young person is trying to move away from their childhood objects. If transference is addressed too early, adolescent patients will be unable to distinguish between past and present objects, and react as if to the primary objects they are trying to separate from. The result is likely to be

dropout. It is better for the analyst and patient to work out together whether the storms of adolescence represent continuity between childhood and adulthood, or whether they indicate a hurricane of emotional and behavioural disturbance pointing to emerging personality pathology. An initial task is to create a narrative of the impact of earlier experiences, including an understanding of attachment experience on emerging emotional regulation and social engagement.

The first task, though, is to engage the young person in the analytic process. Some adolescents, especially those who self-refer, make excellent use of treatment and engage easily, but for others the process is stormy. Any relief from anxiety offered by analytic treatment is attacked because it is experienced as shameful, evoking regressive wishes of being cared for, held, and looked after. The conflict between the wish to be cared for and the desire to be independent is externalised (Chused, 1990). The analyst becomes a persecutor who is responsible for the pain and needs to be kept at bay. The young person's experience of painful feelings is turned around and inflicted on the analyst, whom he may deride and taunt, sometimes with threats of suicide or violence. Breaks, weekends, and absences on the part of the analyst are all felt as counterattacks and are often dealt with by action, turning passive into active. The adolescent will leave before a break, fail to attend on Friday, come for sessions at whim, and may be silent for long periods, especially if the analyst is himself silent, possibly as a mocking or ironic riposte. Sometimes the reverse applies: the analyst is idealised, seen as omniscient and the cure for all ills. This, too, may present difficulties. Initial relief at the offer of help leads to an eagerness to talk, but later may turn to wariness and shame at having revealed too much.

Before beginning analysis with an adolescent, it may, for two very practical reasons, be necessary to initiate contact with the parents. First, in contrast to adults, whose parental figures are active primarily in the internal world, adolescents continue to deal directly with their parents, who exert their influence externally as well as internally. Arguments, fights, rejection, collusion, over-involvement, and excessive protection are common. Second, analysis of patients in early adolescence can happen only with parental support. Parents are needed to support the stability of the setting, and ensure regular attendance and that treatment is neither interrupted by holidays nor prematurely terminated. They may be paying for the treatment. Therapeutic support for the family may also be necessary.

Once analysis has begun, analysts should not fall into the trap of trying to reassure patients that they are somehow different and "better" – more empathic, less demanding, and so on – than the patient's parents. Adolescents will conflate their analyst with their parents and assume they share the same beliefs and outlook. The analyst needs to draw attention to this rather than try to prove how different he or she is. There will be pressure to collude with the denial of problems, as the patient tries to repress feelings of shame and

guilt about the wish to be cared for and helped. Suicidal acts will be minimised in importance. It is terrifying for adolescents to realise that their actions are a result of their inner experiences rather than the fault of others. The task of the analyst is gradually to help the patient (a) to accept internal conflict; (b) to understand that internal and external, past and present, can be differentiated; (c) to tolerate impulses without acting on them; and (d) to recognise that the struggle for autonomy is hindered as much by internal conflicts as by external objects.

Analysis with older patients

Respect for "elders" is integral to Asian cultures, but until recently less so in the western world. But there is increasing evidence that in industrialised western countries with good healthcare the elderly are increasingly respected and even envied as being able to have an active and productive lifestyle (North & Fiske, 2015). From the psychoanalytic viewpoint, there is no clear definition of the age at which someone becomes an "older" patient. Freud (1904) suggested that patients beyond middle age were not suitable for analytic treatment. He was concerned about the vast amount of psychological material to be covered and the inflexibility of mental processes after that age. This view has been increasingly questioned, and age is no longer seen as a bar to psychoanalytic treatment (Ardern, Garner, & Porter, 1998; Plotkin, 2014). The unconscious does not age; the individual may wish to revise earlier narcissistic ideals and to accept the limits of the physical body. The patient will hope to reconcile the realities of the time-bound body co-existing with a timeless unconscious. There will be a hope to rethink and reorganise one's self-narrative within a whole life trajectory (Quinodoz, 2009). The question for the assessing analyst is not how old someone is, but whether that person is suitable for analysis. The assessment of an elderly patient is essentially no different from that of other patients (see Chapter 7). The elderly patient who continues to seek new experiences, form meaningful relationships, and remain active is likely to show the psychological flexibility needed for analysis. Older patients who are reconciled to their achievements, show a wisdom born of their experiences, and have stable values have a good prognosis. Some elderly patients have had psychotherapeutic treatment in the past, although it may have been of limited success; others may seek treatment in old age beset by fears of death (Segal, 1958), conscious or unconscious. Another motivating factor behind a request for help is the "last chance saloon syndrome" (Hildebrand, 1990; King, 1980) – the wish to find peace of mind after a lifetime of turmoil, failed relationships, and self-destructive choices.

For elderly people, death is no longer a general concept but an increasingly brute fact as they face the crisis of "integrity versus despair" (Erikson, 1968). Death has its own private meaning to each individual, but Jacques

(1965) suggests that unconsciously the phantasy is one of immobilisation, helplessness, and fragmentation of the self while maintaining the ghostly ability to experience the resulting torment and persecution. Along with this, there is a continual requirement for the elderly to face up to the ageing process itself: declining physical abilities, loss of relationships, diminishing sources of self-esteem, and increasing dependency (Valenstein, 2000). Facing these issues is painful, not only for the patient but also for analysts, whether young or old (Kastenbaum, 1964). Unresolved feelings about the analyst's own ageing and death, and identification with the patient, may stimulate complex transference and countertransference (Plotkin, 2000) – earlier literature discussed unresolved rescue phantasies or hostile feelings related to the analyst's own parents being enacted with the patient (Myers, 1984, 1986), fears of intense dependency interfering with the therapeutic process (Martindale, 1989), and terrors of loneliness in the analyst leading to mutual dependency between patient and analyst (Cohen, 1982; Treliving, 1987).

Patients on psychotropic medication

The undesirable polarisation of psychoanalysis and pharmacotherapy may be responsible for the limited discussion in the literature of the use of medication during psychoanalytic treatment (Gorman, 2016). It is commonly believed that "drugs" dampen down the feelings that are the basis of analytic work and foster denial of the underlying psychological factors contributing to psychological illness. Conversely, psychoanalysis may unearth previously submerged and intolerable painful symptoms that can be managed only with medication. Either way, psychoanalysis and psychotropic medication intersect (Kaplan, 2014). There is good evidence of the benefits of combined therapy in many illnesses, although this is primarily for medication plus psychotherapy rather than specifically psychoanalysis. In moderate to severe depression, a combination of antidepressants and psychotherapeutic treatment results in a better outcome in terms of social functioning and symptom amelioration than either treatment alone (Khan, Faucett, Lichtenberg, Kirsch, & Brown, 2012).

A number of options for prescribing are available to medical analysts, who are increasingly seen as a resource for potential patients who have a formally diagnosable mental illness. These are often categorised as either combined or "split" treatments, or both. The analyst may diagnose the condition, prescribe, and instigate or continue the psychoanalytic treatment themselves (combined); or diagnose and refer to another psychiatrist while continuing their psychoanalytic treatment and liaising with the prescriber (combined/split); or refer the patient for further diagnostic assessment, requesting consideration of psychotropic medication, and isolate the psychoanalytic treatment from the psychiatric management (split). There is no clear agreement about the best course of action (Lebovitz, 2004). Some

authors prefer a fully split system to protect the transference and to prevent the analytic process becoming overtaken by discussion of medication dosage and side effects (Sandberg, 2014); others recommend the integration of prescribing and discussion of the effects of medication as part of the overall analytic relationship, to avoid any negative effects of referring a patient elsewhere (Scull, 2010).

Loeb and Loeb (1987) and Jackson (1993) discuss the necessity for medication and hospital care in the psychoanalytic treatment of bipolar disorder. Through psychoanalytic treatment, patients were able to recognise some of the unconscious precipitants of their manic episodes, titrate their medication accordingly, and control their impulses better. More work has been done on schizophrenia, after it was found that psychoanalytic treatment alone was ineffective. Rosenbaum et al. (2012, 2005) report better outcomes for patients treated with psychodynamic psychotherapy plus "treatment as usual" (TAU; i.e., medication and supportive management) compared with patients treated with TAU alone. Weijers et al. (2020) report significantly better social function and understanding of complexity of mental states in patients treated with mentalisation-based treatment plus TAU compared with TAU alone.

Psychoanalysis and pharmacotherapy are not intrinsically competitive or antagonistic treatments. Each has a different aim and is effective over a different time scale. Integration offers better outcomes for patients. As psychoanalysts take on more seriously ill patients, these integrative approaches are becoming more common. Patients can begin analysis while they are already taking medication, and may require medication in the course of analytic treatment. How the analyst deals with this aspect of treatment, and how the patient uses the medication, may have a profound effect on the course of analysis. However, denial of the value of drugs, or overvaluation of their efficacy, may interfere with the analytic process, as the following contrasting examples illustrate.

Example: Drug denial

A patient, already on medication at the beginning of analysis, cut down her medication without discussing it with her psychiatrist, with the intention of stopping it, believing that her non-medical analyst was "anti-drugs". Exploration of this fantasy indicated that analysis was idealised as "good" treatment, and medication as "bad". The patient lied to her psychiatrist that her analyst had advised cutting down her medication. In fact, the analyst felt that any reduction of the patient's medication was part of a denial of her psychotic illness and that

acknowledging her need of medication was a step towards health. Only regular discussion between the analyst and the psychiatrist about medication within a well-organised split treatment prevented an enactment of the patient's polarised views.

Example: A denigrating drug

A patient with BPD continually denigrated her analyst, quoting newspaper articles critical of psychoanalysis. Despite her rage, she attended regularly and rarely missed a session for over a year. Continuing her barrage of incessant criticism, she demanded medication following a series of reports about a new antidepressant described as a "wonder drug". The analyst felt helpless and nonplussed in the face of her onslaught. He was relieved when she visited a private psychiatrist, who prescribed the new drug for her. She brought the tablets to the next session, announcing that she was going to take the first dose of her "cure". Taunting the analyst, she swallowed the tablet and left the session. The following day, she reported that she felt better than ever before. Recognising that this must be a placebo effect, and taking into account his countertransference reaction, the analyst began to take up her sense of triumph in believing that she had defeated his attempts to help her, leaving him helpless and humiliated. She was now in control. The patient retorted that he should have reached out and stopped her taking the tablet in the session. The analyst took up the cruel elements in her taunts, and her need to remain in control and be out of his emotional reach. It seemed that she felt she could get close to her object only in this sado-masochistic way. Taking a pill allowed her to feel that *she* could decide when someone "got inside her", rather than being emotionally invaded as she felt had been the case as a child, especially when sexually abused by an uncle. Gradually, the patient's contempt became available for exploration and she stopped the antidepressant, which had, in reality, made little difference to her symptoms.

The important point is that the *meaning* of medication, whether prescribed by the analyst or another medical professional, is analysed in the transference. As in the example of the patient with BPD, what is the specific meaning of the medication to the patient? If the analyst prescribes the medication him/herself, is this a "lone parent" message? Does combined therapy represent a loving couple, or non-communicating parents? What

countertransference feelings are engendered in the analyst – omnipotence, friendly co-operation, or helpless impotence?

Example: An open verdict

A patient who had been in analysis for 2 years became severely depressed. She had never seen a psychiatrist in the past, nor had she needed medication. It was not the medical analyst's policy to prescribe medication, and he referred her to a psychiatric colleague. The patient refused to attend the appointment, demanding to know why she had to see someone else and stating that if the analyst thought medication was required he should have prescribed it. It transpired that she felt the analyst was unable to cope with her suicidal and hostile feelings and that he was trying to get someone else to "do his dirty work". This related to her experience of her mother, who was herself chronically depressed throughout the patient's childhood, always asking her father to "take her off her hands". Eventually she agreed to the appointment and was prescribed an antidepressant. The drug had marked side effects and, even though the analyst had not prescribed it himself, she experienced him as having poisoned her, refused further medication, and considered terminating analysis.

Would it have been better for the analyst to prescribe himself in this case? If he had, some of the rage may have been avoided but perhaps his role of "poisoner" would have been heightened. To have acquiesced to the patient's demand may have fuelled an omnipotent phantasy that she could control the analyst, escalating acting out. On the other hand, if the analyst had prescribed medication, this may have led her to have greater trust in him as a result of his decisiveness. On balance, the analyst erred on the safe side and maintained his analytic role.

The analyst also needs to question whether countertransference feelings or personal opinion are complicating the use of medication. This can work both ways. On the one hand, the analyst may not wish to accept the limitations of his treatment or his theory, and may therefore fail to suggest medication when he should; on the other hand, he may suggest psychopharmacology out of frustration, anger, and hopelessness, which should be dealt with analytically. Clearly, whenever medication is used, it becomes relevant to the analytic process. The task of the analyst is not to take sides in the psychoanalytic/pharmacological debate but to ensure that the effect of medication on the therapeutic process is constantly scrutinised, with special regard given to the transference–countertransference relationship (Iannitelli, Parnanzone, Pizziconi, Riccobono, & Pacitti, 2019).

Money

Ever since Freud (1908) compared the symbolic meaning of giving and withholding to defecation, and linked faeces with gifts and money in a "symbolic equation", the literature on the meaning of money has been plentiful. In contrast, comment on the significance of money as a transaction within analytic treatment, and the influence of the source of finance on the treatment process, has been muted. Thomä and Kächele (1987) summarise its importance in their seminal textbook. In countries with high inflation or where payment is fixed by insurance companies or government schemes, as in Germany and the Netherlands, fees are part of an external reality shared by analyst and patient alike, although confidentiality of clinical information and interference by third parties may be of concern. Where they are part of a private contract, however, analysts tend to analyse financial matters within the transference relationship rather than concentrate on reality. Late payments may be seen as resistance, offers of cash as an attempt to draw the analyst into a joint criminal act of tax evasion, and sending the bill to a private insurer as a way of avoiding an intimate transaction with the analyst. Conventionally, bills are given to the patient at the same time each month, with payment due at the time agreed.

There seems to be an unspoken and largely unquestioned consensus that there is a hierarchy of which source of payment is preferable. Direct payment by a patient, unsupported by outside finance, is "best". After that there is an implied slippery slope of payment by relatives, insurance, or government, to questionable free treatment, even if funded indirectly through taxation. Payment by relatives adds complexity to treatment, as payments may become the vehicle of the family dynamics, leaving the patient dependent and in a constant state of anxiety that treatment could end at any moment should the family member withdraw financial support. Being paid for may limit personal motivation; self-pay increases self-determination, reduces gratification of narcissistic wishes, and keeps the patient in touch with reality. Training institutes insist that a patient makes a contribution to treatment, dependent on earnings, to enforce a necessary sense of reality. However, direct payment by a self-sacrificing patient to a better-off analyst must also result in palpable transference–countertransference problems potentially involving resentment, envy, and hostility. Eissler (1974) found few problems in payment by relatives, although in some circumstances it may cause difficulties.

Whatever the source of finance, money has a significant part to play in all analyses, although it seems not to influence outcomes (Yoken & Berman, 1987). Each payment method brings its own advantages and disadvantages, and opens up channels for phantasies, fears, enactments, and defences. Where treatment is free or heavily subsidised, special attention needs to be paid to underlying wishes to be a "favoured" patient and fears that

expressing hostile feelings might jeopardise treatment. In the case of third-party payment, the patient and analyst need to be careful not to collude in minimising the importance of payment or indeed ignoring it completely. Third-party payments are often below normal analytic fees, and so co-payments are often necessary. This can lead to countertherapeutic interactions such as self-sacrificing overgenerosity on the part of the patient above their means or, conversely, analysts lowering their fees excessively (Akhtar, 2009). Direct payment may give rise to transferences involving control, power, envy, dominance, avoidance of dependence, and self-sacrificing masochism.

There may be equally significant influences on analysts who rely on their patients for their living: they may hold on to wealthy patients while feeling less concerned about those paying less; resent patients who are subsidised, feeling they have it too easy; keep patients in treatment for too long; and slant recommendations for treatment according to their own vacancies. On the other hand, benefits can accrue from the patient–analyst financial interaction, which becomes an "analytic third" bringing meaning and life to the relationship (Pauley, 2019) or a gateway into the patient's oedipal configurations (Carrington, 2015). Reik (1922), one of the analytic pioneers, provides an interesting discussion of the moral dilemma presented to him by a millionaire who offered to pay him a huge fee – which would have enabled him to pursue his writing and research – on condition that he was his only patient.

In general, the attitudes of a patient and his analyst to money may be more important than the source of funding. Many analysts offer some patients treatment for a discounted fee, and younger analysts often continue with their training patients for many years. The fee should not be so low as to lead to resentment or so high as to result in greed or excessive reliance on one patient for income. Most analysts would agree with Freud (1919, p. 166) that "the poor man should have just as much right to assistance for his mind" as the well-off. How this can be achieved, and whether it should be achieved, is a topic requiring further debate.

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Chapter 10

Psychoanalysis and mental health practice

> Psycho-analysis is related to psychiatry approximately as histology is to anatomy; the one studies the external forms of the organs, the other studies their construction out of tissues and cells. (Freud, 1916, p. 254)

Our original aim in writing this chapter was to consider the specific psychoanalytic contribution to the understanding and treatment of the variety of different psychiatric diagnoses – obsessional neurosis, the addictions, schizophrenia, manic depression, personality disorders, and so on. Freud's distinction between what he called the "actual neuroses", which would now probably be classified as panic attacks, and "anxiety neurosis", a more diffuse sense of worry or dread, has stood the test of time, even if his theory that the "actual neuroses" result from sexual frustration has not. He addressed psychiatric classification by differentiating the mechanisms underlying anxiety neurosis, depression, and psychosis: "Transference [i.e., anxiety] neuroses correspond to a conflict between the ego and the id; narcissistic neuroses [i.e., depression], to a conflict between the ego and the super-ego; and psychoses, to one between the ego and the external world" (Freud, 1924, p. 151).

But here, we encounter a number of problems. First, as Freud's formulation reveals, psychoanalytic thinking is highly theory-laden, whereas psychiatry attempts to make a clear differentiation between the *description* of the phenomena of illness and causal *explanations* for their occurrence. For Freud, each disorder was related to the central psychoanalytic concept of psychological *conflict*. But, as we have argued throughout, a model of non-conflictual *deficit* is also needed to encompass the devastating effects of mental illness, a shift characterised by Kohut (1977) as a move from "guilty man" to "tragic man". Freud also tended to pick up on one aspect of an illness – overactive conscience in depression, or repetitive rituals in obsessive-compulsive disorder – and build his theory around that, while glossing over aspects that failed to fit his theories.

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Second, contemporary psychoanalysis is more concerned with psychological *processes* than specific *disorders*, and with the uniqueness of the individual, a more dimensional approach to mental disorder, than broad categories of diagnosis (see Chapter 4). Third, for theoretical and pragmatic reasons, "full" psychoanalysis as a specific treatment is exclusive to a restricted number of psychiatric patients, whereas psychiatry is concerned with the whole range of therapies – biological, social, and psychological – and included among the latter are cognitive-behavioural and systemic therapies as well as psychodynamic therapies. Fourth, psychoanalysts and psychiatrists often use the same words to mean different things; for example, "psychotic", "borderline", and even "defence mechanism". Finally, while psychiatry aims for specificity, psychoanalytic formulations and treatments tend to be elastic and broad-spectrum – for example, the notion of projective identification is relevant to patients with addiction, eating disorders, borderline personality disorder (BPD), paranoid psychosis, and perversion.

In approaching this topic, we have returned, therefore, to Freud's analogy between anatomy (psychiatry) and histology (psychoanalysis). Psychiatry, through its diagnostic schemata – the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013) and the *International Classification of Diseases* (ICD-11; World Health Organization, 2018) – anatomises and categorises the variety of psychiatric illness, although currently edging towards a dimensional system. Histology is concerned with general pathological processes – such as response to injury, tissue repair, degenerative changes, and autoimmune diseases – which apply to a wide range of different illnesses. Similarly, psychoanalysis can provide insight into the underlying mechanisms and meaning of a variety of different mental disorders. While strictly psychoanalytic treatments may be applicable mainly to a relatively restricted group of people with mild to moderate personality disorders, a psychoanalytic perspective can illuminate the general and psychotherapeutic management of many illnesses, including somatisation disorders, and can be especially helpful in understanding countertransference reactions among staff looking after difficult patients (see later in this chapter; and Yakeley, 2018).

Thus, Kernberg's (1984) "borderline personality organisation" (BPO), a constellation of defences and psychological dispositions, can be applied to BPD, narcissistic personality disorder (NPD), and antisocial personality disorder (ASPD). Similarly, Klein's (1946) depressive and paranoid–schizoid positions, or Steiner's (1993) "pathological organisation" and "psychic retreats", are not specific diagnoses but modes of thought and behaviour, constellations or nodal points in the spectrum of mental activities that help one to think about the inner experience of psychological illness. Following this tradition, we divide our discussion into three broad categories of abnormal mental processes: *psychotic* processes, *borderline* processes, and *affective* processes.

Psychotic processes

The psychoanalytic project began, and to an extent remains, an attempt to make meaning out of the seemingly incomprehensible and maladaptive phenomena of mental life – such as dreams, slips of the tongue, and hysterical symptoms. By placing "madness" – the non-rational primary processes – at the heart of psychic life, Freud opened up the possibility of understanding psychosis. It is certainly true, as we shall see, that personal meaning is to be found in psychosis, but understanding should not be confused with explanation. As an example, until the discovery of a chromosomal abnormality (trisomy) in 1956, Down syndrome was thought to be caused by physical or emotional trauma in pregnancy, since, when closely questioned, mothers of babies with Down syndrome were much more likely to recall traumatic incidents than those with unaffected offspring. Thus, the personal *meaning* of the experience of Down syndrome has no connection with its actual *cause* – an abnormality of cell division in the formation of the ovum leading to trisomy. Psychoanalytic accounts of psychosis strain to explain what they could more accurately be thought of as describing.

The psychopathology of schizophrenia

Freud's first attempt to understand paranoid schizophrenia came in his analysis of Judge Schreber's autobiographical account of the psychotic episodes that punctuated his life (Freud, 1911). Freud saw Schreber's delusion of the end-of-the-world catastrophe as a reflection of the internal catastrophe of his illness, a regression to a primitive state of narcissism in which "a person's only sexual object is his own ego" (Freud, 1911, p. 71). Having withdrawn from the world, the paranoiac, in Freud's view, then proceeds, by projection of his inner world on to the outer, to build it up again in a delusional way: "The delusional formation, which we take to be the pathological product, is in reality an attempt at recovery, a process of reconstruction" (Freud, 1911, p. 70); a "delusion is found applied like a patch over the place where originally a rent had appeared in the ego's relation to the external world" (Freud, 1924, p. 150). Freud's prescient formulation, considered by Holmes (2020), was that coherence and integration, however removed from consensual reality, are psychologically preferable to chaos and disintegration.

Freud's three themes of regression, narcissism, and projection form the basis of most subsequent psychoanalytic accounts of psychosis. Freud considered patients with schizophrenia unanalysable because their self-absorption made them incapable of forming a transference relationship with an analyst. In the 1950s, pioneering units such as Chestnut Lodge in Maryland, USA, were staffed by outstanding analysts including Harold Searles and Frieda Fromm-Reichman, who wrote freely about psychoanalytic therapy for

psychosis (to be weighed alongside her many virtues, the latter was also responsible for the egregious misnomer "schizophrenogenic mother"). Following Melanie Klein's accounts of manic-depressive psychosis, Bion (1957) and Rosenfeld (1987) similarly wrote and upheld the view that psychotic illness could be understood and treated psychoanalytically. However, many patients with schizophrenia treated psychoanalytically failed to improve, or even deteriorated. McGlashan (1984a, 1984b, 1986), a former Chestnut Lodge staff member, published a follow-up study of patients with schizophrenia showing that psychoanalytic therapy was contraindicated, ironically in line with Freud's caution first expressed nearly a century earlier.

Few, if any, would now see psychoanalysis as a first-line treatment for schizophrenia. But even in the Chestnut Lodge era, Searles (1963) had argued that the psychoanalytic treatment of patients with schizophrenia requires much modification of technique. A psychoanalytically informed "needs-adapted" approach to schizophrenia has been developed in Scandinavia. The components of this approach include recognition of the value of each patient and their individual life trajectory, minimal medication, intensive family therapy, and establishing a long-term relationship with a keyworker (Alanen, González de Chávez, Silver, & Martindale, 2009). This programme is not formally psychoanalytic, and it contains elements of support and attachment, but the aim is to help patients understand the nature and meaning of their illness and its origins rather than simply seeing it as a biologically determined "disease".

Meanwhile, other research has revealed the widespread nature of psychotic symptoms, and the role of childhood adversity and trauma as precursors to the development of psychotic illnesses (Bhavsar & Murray, 2015), strongly suggesting that the family and wider social environment may crucially determine whether particular thinking styles become psychiatric illnesses. This lends some support to the Lacanian idea that psychosis reflects a retreat into the world of the "imaginary", as opposed to the "symbolic", and that in the absence of a loving father able to help mediate this maturational step, psychosis supervenes (Fink, 2011). It has also been argued (Debbané et al., 2016) that attachment and mentalising, concepts closely associated with psychoanalysis, may represent key protective factors that can (a) attenuate the clinical course of emerging psychosis in those at increased risk and (b) sustain recovery in affected individuals. In other words, a mentalisation-based approach to psychosis seeks to enhance protective mechanisms in the early part of the disease, and to strengthen the "non-psychotic" part of the personality (Bion, 1957) in affected individuals, to promote partial or complete recovery.

Freud remained neutral about the aetiology of psychosis. Some post-Freudian psychoanalysts have tried to relate the regression to faulty parental attunement in the first few months of life (Fromm-Reichmann, 1959; Stolorow, Brandchaft, & Atwood, 1987): Schreber's father was cruel and

abusive to his sensitive son (Schatzman, 1973). But as the evidence for a biological basis for schizophrenia accumulates, the notion of schizophrenogenic parents has, rightly, been increasingly discredited.

A more plausible account of the role of dynamic factors in psychosis assumes a biologically based abnormality leading to the breakdown of the normal perceptual and experiential boundaries between the self and the external world. Whether this is a true "regression" to normal but primitive modes of thinking is open to question. It seems unlikely that all babies' experiences of the world are "schizophrenic" (Gabbard, 2000). But, especially in the face of environmental adversity, infants probably at times do feel powerless and confused, and experience the world in an animistic way in which objects are imbued with projected feelings. The ego then tries to contain and make sense of the primary process material (see Chapter 2), normally kept repressed, with which it is flooded. Drawing on Bion's model, Grotstein (1984, 1986) sees a primary failure of "stimulus barriers" – to both external and internal stimuli – which leads to excessive projective identification as an attempt to keep the ego from being overwhelmed. For Roberts (1992), delusions represent the attempt to maintain meaning in the face of threatened chaos, and are likely to be suffused with personal themes, just as dreams combine the day's residue with the dreamer's deeper preoccupations. The "strength" of the ego reflects previous favourable or adverse experiences. Thus, childhood trauma, and later parental negativity or overinvolvement, may influence the way a biological propensity to schizophrenia is expressed.

Kleinian views

The most concerted psychoanalytic attempt to understand the phenomenology of psychosis has come from the Kleinian school, especially through the work of Bion, Rosenfeld, Segal, Rey, and Sohn (Hinshelwood, 1989; Rey, 1979; Spillius, 1988). They identify abnormalities in feeling, thinking, and relating, with consequent defensive responses. The following is an attempt to summarise their views.

Affect

Schizophrenia is characterised by an excess of destructive impulses, in which reality, both internal and external, is regarded with violent hatred. The origin of this hatred is not really explained, but sometimes attributed to "constitutional factors" or the "death instinct" (Segal, 1993). Hatred is linked to envy: the sufferer is enormously envious, for example, of the "good" qualities of the maternal breast, and transferentially of any therapeutic help he or she may be offered. The patient also turns hatred inwards towards such potentially positive feelings as guilt or even the recognition of

psychic pain itself. The projection of hatred (discussed later in this chapter) is therefore a fundamental defensive manoeuvre in these patients. When this fails, self-murderous feelings emerge, accounting for the high suicide rate in individuals with schizophrenia (around 10% of those diagnosed with the disorder).

Some authors have been critical of this conflict-based model. For them, to say that the psychotic has a hatred of reality is rather like saying that a one-legged person has a hatred of walking! Emphasising deficit rather than conflict, Winnicott (1965), Laing (1960), and Searles (1963) describe the basic affective state in schizophrenia as a *dread of annihilation* due to the lack of a stable integrating autonomous ego, and relate this to presumed maternal neglect or, conversely, intrusiveness in infancy.

Cognition

For Bion (1957, 1962), schizophrenia is dominated by what he calls "minus K", the desire not to know, due to failure to transform "pre-conceptions" (beta elements) into "conceptions" (alpha elements) via the transmuting introjected maternal breast (see Chapter 3). Creative thought depends on bringing ideas and words together so that transformational "intercourse" can occur between them. What is found in schizophrenia, he claims, is an "attack on linking", a precursor of the oedipal child's envy of the parental sexual relationship. Segal (1986) emphasises the presumed "concrete thinking" of psychosis, in which symbol and reality become confused, leading to what she calls the "symbolic equation" (see Chapter 6). Thus, using Winnicott's idea of "hate in the countertransference", the non-psychotic patient might say that the end of an analytic session or a break made him feel "as though you can't stand me, want to get rid of me", whereas the psychotic patient might actually experience the break as a murder, rather than, as with the neurotic, merely symbolically murderous.

Both of these viewpoints emphasise phenomena that are far from universal in schizophrenia; some patients are highly creative (not excluding one of the analytic pioneers, Wilhelm Reich). For Segal, creativity requires transcendence of the symbolic equation. But symbolism and concrete thinking often exist side by side, when, for instance, a patient attends for an appointment while simultaneously claiming that the doctor is a murderer. This fits in with Bion's idea of the psychotic and non-psychotic parts of the personality, the analyst's task being to establish contact with the latter to reach the former. As Searles (Mullen, personal communication, 1973) put it, "the analyst must use the mad part of himself to make contact with the sane part of the patient".

Example: Post-psychotic depression

Mary had had schizophrenia for 20 years. Now in her forties, with her symptoms controlled by medication, she entered analysis to try to cope with what she called her "whirling attacks". During these episodes, she would lie on the bed and moan for hours while her distraught mother, with whom she lived, would watch helplessly. In analysis, it soon became clear that during these moments she was in fact feeling terrible panic as she contemplated the devastation in her life that her illness had wrought. She saw how all her youthful ambitions had come to nothing, and that it was unlikely she would marry, have children, or find a job commensurate with her talents and intelligence (which had been considerable). As she began to moan in her sessions, complaining that the analyst was doing "nothing" to help, the regressive aspect became apparent: she was like a miserable 3-year-old simultaneously intruding, attacking, and craving love. Gradually, she began to own the feelings during these episodes, rather than seeing them concretely as "attacks", and as she mourned the many losses the illness had brought, she was able to form a tentative relationship with a man who, although "unsuitable" and unacceptable to her mother, was someone she could care for and cherish in a way she had longed to be looked after herself.

Relationships

Object relationships, while not, as Freud thought, non-existent in schizophrenia, are certainly problematic. Bion described transference in schizophrenia as "thin", "premature", and "tenacious". Rey (1994) sees the schizoid dilemma as claustro-agoraphobia – a desperate loneliness and at the same time a terror of intimacy (Mizen, 2014). Rosenfeld (1987) emphasises the "parasitic" aspect of schizophrenic relationships, a defence, as he sees it, against separation anxiety, in which the patient attaches himself to carers or institutions in a passive, dependent, embryo-like way, feeding off them without any real reciprocity. There is certainly a static or even repetitive aspect of much interaction in schizophrenia, which is as much the result of the inherent deficits of the schizophrenic state as of defensive manoeuvres.

Defences

Nevertheless, a number of characteristic defensive patterns are commonly found in an attempt to maintain psychic coherence in the face of cataclysmic internal chaos. Fragmentation and helplessness may be compensated by

omnipotence and idealisation, as Freud (1911) noted with Schreber's delusional communication with God. Hatred of reality is dealt with by grandiosity and triumph over the envied object. Feelings of destruction are projected. Bion (1957) describes the schizophrenic world as inhabited by "bizarre objects". These are elements of the fragmented self projected into the outside world. For example, a patient who feels that the television is sending frightening messages to him has projected a malevolent part of himself, which now confronts him in a way that is frightening, but perhaps less terrifying than if the hatred had remained entirely within him.

Example: Psychotic embarrassment

A man in his twenties was horribly embarrassed by his "big penis", which he felt everyone would notice and which prevented him from going out in the street. He came from an ambitious family in which his brothers and sisters had all done very well academically. All had spouses or partners. His illness and social and academic failure were a constant source of humiliation to him. He heard voices telling him to harm members of his family. He wanted to live with his parents, but his continuous angry outbursts and search for reassurance had exhausted them, and he had moved into a hostel. His "big penis" could be seen as a "bizarre object", which contained his omnipotence, his longing for closeness but also feelings of being "too much to handle", his desire for triumph, and his aggression. The feelings around this "bizarre penis-object" – as a concrete manifestation of his mental and body image distortions and exclusion from intimacy – embarrassed him but were not entirely overwhelming, as they might have been had he not externalised them in this way.

The ego in psychosis

Rosenfeld's (1952) and Sohn's (1985) formulations concentrate on the nature of the ego in psychosis. Freud (1923, p. 28) saw the ego as a "precipitate of abandoned object-cathexes", that is, as reflecting a synthesis of internalised parental and other influences. What happens in psychosis where the "narcissistic" ego has withdrawn from other people? Now the ego is seen as fundamentally split, with a "pathological identification" in which the object (an unresponsive or abusive caregiver, for example) is omnipotently taken in without being fully integrated or assimilated into a coherent self, forming an "incorporated object". Good objects are squeezed out, while the threatening object is held within in an idealised way rather than actually

related to, with all the dangers that implies for the oversensitive schizophrenic. Sohn (1985) calls this pathological introject "the identificate", a sort of unintegrated foreign body that can dominate and take over the personality, or form – in Rosenfeld's striking metaphor – a Mafia-like gang that dominates and obscures the fragile non-psychotic self. Fonagy and Target (2000) have incorporated a similar model into their "alien self" theory of borderline functioning.

All this leads, in a Manichean way, to a swing away from life to anti-life, from love to hatred, from relationships to omnipotent self-sufficiency, from Eros to Thanatos.

Example: Murder and salvation

A divorced woman in her thirties became convinced that there was a plot against her and that her life and that of her 9-year-old daughter were in danger. She had been regularly sexually abused by an uncle at the age of 9. When a taxi driver asked if she lived on the left or right side of the street, she "knew" that the left side was the devil's side and that she and her daughter were in mortal danger. Later that evening, when her daughter was asleep on the sofa, she saw her making what she thought were pelvic thrusting movements. Again, she "knew" that the devil was having sex with her, and violently attacked both her daughter and herself with a knife in a vain attempt to protect them both. Here, the tragic "identificate" could be thought of as containing the abusing uncle projected into the "devil", and then re-introjected into herself and her daughter, whom she attacked with such utterly psychotic ferocity.

Therapeutic strategies

Conflict and deficit models of schizophrenia lead to two differing psychoanalytic therapeutic strategies. Interpersonal psychoanalysts such as Searles, Fromm-Reichmann, Sullivan, and Winnicott tried to make good the hypothesised lack of maternal attunement and consequent ego deficit in the early months of life by advocating a flexible, hyper-empathic stance with prolonged daily or even twice-daily sessions, and an emphasis on non-verbal and intuitive elements in the therapeutic relationship. Rosenfeld and Bion, by contrast, stressed the need to contact the conflicted non-psychotic part of the self by the use of words and accurate, if sometimes extravagant, interpretations.

Example: A wild interpretation

An over-enthusiastic trainee saw a disturbed young paranoid man with schizophrenia in the emergency clinic one evening. The patient had had a row with his girlfriend, who, he then became convinced, was plotting against him and who had informed the media that he was a homosexual. The trainee saw him for three or four follow-up sessions, in the course of which he made a number of quite powerful "conflict"-type interpretations, including one based on Chasseguet-Smirgel's (1985) notion of the "faecal penis", that is, an omnipotent quasi-delusional attempt to deny the reality of oedipal or pre-oedipal helplessness and inadequacy. Some 5 years later, he received a letter out of the blue from the patient, which stated: "You may recall how you told me when we met 5 years ago that 'my trouble was that I thought my penis was made of shit'; well, I have come to the conclusion that you were completely right..."!

As mentioned earlier, conventional psychoanalysis is rarely if ever indicated in the present-day treatment of acute schizophrenia, although psychoanalytically informed management strategies can produce good results (Alanen et al., 2009). Self-psychologists/Interpersonalists such as Stolorow (Stolorow et al., 1987) advocate a supportive therapeutic stance, and criticise the emphasis on aggression and hate and general negativity inherent in Kleinian approaches, which, they argue, reinforce the patient's already fragile self-esteem. Where a supportive psychoanalytically informed approach is tried, flexibility, holding, a need to limit regression and to focus on the here-and-now, and "respect for the illness" (Gabbard, 2000) – that is, not seeing it as something for which the patient, albeit unconsciously, should be held responsible – are essential. The emphasis is on strengthening the non-psychotic part of the personality. This can be done by cognitive strategies in which the reality of the psychotic experiences is challenged (Chadwick, Sambrooke, Rasch, & Davies, 2000) and by concentrating on separating the healthy part of the self from the identificate or "cohabitee", by asking the question "Who is the mad voice inside?" (Sinason, 1993).

Example: The African queen

Rosy was a normally quiet, friendly, submissive, divorced woman in her late twenties who had had several schizoaffective episodes in which she had become floridly deluded – on one occasion living for nearly a week naked at the bottom of her garden, saying that her voices had

told her she was "Eve" and was in paradise. She had two children who, due to her illness, had been taken into care but were now happily settled with their father's parents. Rosy came from Uganda and had, with her sister, been "rescued" by a missionary at the time of the Amin regime. Her mother, who had apparently been mentally ill, had died, and Rosy had been brought up by her father, who sexually abused her, and was subsequently killed in the civil war. Normally quiet and submissive, in one psychotic episode she became very violent and threatening, shouting that she was "Nafekerra", an African queen with healing powers, and that those who crossed her did so at their peril. When she had recovered she explained that "Nafekerra" was in fact her mother, who spoke with a deep voice and whom Rosy actually felt dwelling within her, controlling her and uttering sounds for her.

The staff's attempt to "rescue" Rosy from her illness infuriated and terrified this "identificate" internal mother, who felt that her child was being taken from her. Seeing her symptoms in this way helped the staff members to adopt a firm but compassionate management strategy for Rosy. When, thanks to medication, the psychotic storm was over, Rosy could talk about the loss of her own children with great sadness, and linked this to her childhood terror and mental pain when she was whisked away from Uganda.

In summary, psychoanalytic approaches to psychosis can provide useful insights into psychotic processes, help in the general understanding and management of psychosis, and occasionally are indicated as a specific treatment. Flexibility, firmness, and patience are essential, and psychoanalytic treatment should always be carried out in collaboration with psychiatric management, including medication (see Chapter 9).

Borderline processes

The inherently ambiguous term "borderline" evokes an ambivalent response within the psychoanalytic and psychiatric communities. Many authors complain of its imprecision and have proposed its replacement by a more satisfactory formulation, for example, in the major diagnostic systems of the ICD-11 (Tyrer, Reed, & Crawford, 2015; World Health Organization, 2018) and the DSM-5 (American Psychiatric Association, 2013; Skodol et al., 2011). Despite these demands, the term "borderline" has survived and continues in both current classifications. Interest in the nature of borderline disorders and their treatment by modified psychoanalytic methods remains (see Chapter 11). Indeed, the history of the concept suggests that this may well be one of the major contributions of psychoanalysis to contemporary psychiatry.

The psychoanalytic concept of borderline came from a combination of clinical experience and theory. Deutsch (1942) wrote of the "as if" personality, and Zetzel (1968) of the "so-called good hysteric" (who turns out in treatment to be highly disturbed and difficult), and Winnicott (1965) and Laing (1960) of the "false self". Such people exist, as Rey (1994) summarises it, on the borderline between oedipal and pre-oedipal, between psychosis and neurosis, between male and female, between paranoid–schizoid and depressive positions, between fear of the object and need for the object, between inner and outer, between body and mind. These early theorists were trying to capture the essence of people who, while not diagnostically psychotic, evince psychotic mechanisms, can regress dangerously within psychoanalytic treatment, and yet prove challenging – and sometimes rewarding – patients.

The transfer of the term "borderline" from psychoanalytic understanding to mainstream psychiatric diagnosis was the result of the work of John Gunderson, himself a psychiatrist and psychoanalyst and, above all, a researcher. Gunderson (1984) and his co-workers identified a group of patients with a characteristic set of personality features who present frequently to psychiatrists and who pose considerable therapeutic and management difficulties. Gunderson and colleagues set out initial descriptive criteria for a formal diagnosis of BPD, which can be summarised as "stable instability", comprising: intense but unstable personal relationships; self-destructiveness; constant efforts to avoid real or imagined abandonment; chronic dysphoria such as anger or boredom; transient psychotic episodes or cognitive distortions; impulsivity; poor social adaptation; and identity disturbance. These descriptive features allowed standardised diagnostic criteria to be developed and research to be broadened from the clinical case study and psychoanalytic formulation to treatment outcome studies, epidemiology, neurobiology, and genetics, leading to a growing recognition that this was a group of patients whose needs were unmet in social care and health care.

BPD has evoked intense theorising among psychoanalysts and, perhaps because of its clinical difficulty and variability, represents a battlefield on which many of the controversies and schisms of contemporary psychoanalysis have been played out. The main arguments in the latter part of the 20th century, as with psychosis, were between authors who emphasised conflict and those who stressed deficit as the central psychopathological theme, each group advocating apparently very different treatment approaches. The "conflict" group included both the classical Freudians and neo-classical Lacanians, and the Kleinians and their followers, while the "deficit" group comprised, in the United Kingdom, the Independents, and in the United States, the Interpersonalists and self-psychologists (see Chapter 2). In practice, this divide was somewhat artificial: as we shall see, the evidence suggests that both

conflict and deficit are important in the aetiology of BPD, with both intrapsychic and environmental factors playing an important part, and that different authors are probably describing and treating different patient populations with different clinical needs. This recognition has resulted in more refined models of BPD that integrate developmental and constitutional factors with acknowledgement of the centrality of trauma as a vulnerability factor.

Conflict models of borderline

It is often diagnostically difficult to distinguish between BPD and other personality disorders such as NPD, histrionic personality disorder (HPD), and some types of ASPD. Research shows that several different personality disorders can coexist within one individual. Taking this co-occurrence of personality disorders, Kernberg (1984), combining classical instinct theory with Kleinian object relations (see Chapter 3), defined an underlying *borderline personality organisation* (BPO; see Chapter 10), which occurs in many psychopathological situations, including BPD, NPD, HPD, ASPD, psychotic disorders, and some eating disorders, and in clinically normal individuals who are exposed to extreme stress.

Kernberg's BPO has, in attenuated form, many of the features of psychotic thinking described previously. These include the following:

1. *Ego weakness*. This leads to poor impulse control and difficulty in coping with anxiety, and therefore in sublimating instinctual demands into socially acceptable channels.
2. *A shift from secondary to primary process thinking* (see Chapter 2). This is particularly manifest in the dream-like quasi-psychotic states common in individuals with BPD, in which the capacity for reality testing disappears. Thus, they may feel that those who care for or love them actually detest and hate them, which, indeed, by projective identification, they may be induced to do.
3. *The use of "primitive" defence mechanisms*. These include splitting and projective identification, idealisation, denial, omnipotence, and devaluation. The world in BPO is split into good and bad, black and white, friend or foe. Such people swing between feeling all-powerful (often all-powerfully destructive) or helplessly inadequate; rushing from one idealised "answer" to another, only to be bitterly disappointed as each God turns out to have feet of clay. Perceptions of the world are powerfully coloured by projection, and a characteristic feature of analytic work with these patients is projective identification (see Chapter 4) in which feelings are

communicated not only by symbolism or words but also by direct transfer into the therapist's inner world.

Example: Gotcha!

A 50-year-old female patient with BPD spent many therapeutic hours trying unsuccessfully to get some token of love from her male therapist, asking him if he liked her, describing how most men found her enormously attractive, pleading with him to say something that would counteract the contempt and despair she felt she had received from her physically and sexually abusive father, and going into great detail of her romantic and sexual fantasies about the therapist. These entreaties regularly reached a crescendo just before breaks, and were steadfastly interpreted as a response to separation and as an identification with her importuning father, but to little avail. One day, weakened by a session of relentless demands, the therapist explained how if he were to respond to her advances it would completely jeopardise the therapy. He sensed at the time that this was an error, but it did in fact result in a lessening of her demands, and therapy appeared to progress. About a year later, the patient remarked in passing how much she admired the therapist for his strength in restraining his sexual impulses for her sake! When he heard her say this he felt intruded upon, assaulted, and almost physically sick, bitterly realising that his misguided attempt at explanation and reassurance had come home to roost. On clarifying her comment, it was clear that the important point was that she felt that she had at last got him to admit that he really did desire her – as the therapist put it to her: "You felt: Gotcha!" Then, turning to his countertransference, and using "internal supervision" (Casement, 1985), he grasped, not without some difficulty, the projective identification: only by getting him to feel this way could she communicate her own feelings of disgust and self-loathing deriving from her father's sexual assaults.

4. Pathological internal object relations. The inner world in BPO mirrors these external manifestations of splitting and projection. Instead of stable and smoothly integrated internal representations of people and their relationships, the self and others are experienced in chiaroscuro, or as part-objects – breasts, penises, and objects for evacuation or exploitation. At different times the subject is in the grip, in Fairbairn's (1940) terms, of either a split-off libidinal or anti-libidinal self, choosing perversity or self-destruction as a defence against inner emptiness or complete fragmentation.

Kernberg relates BPO to Mahler's "rapprochement subphase" (see Chapter 3) in which the child begins to separate and to explore the world for himself, but needs to rush back to his mother for comfort and reassurance and "narcissistic supplies". If the mother is physically or psychologically unavailable, the child may be unable to integrate good and bad maternal imagos. The child then reacts to abandonment with an excess of aggression, which is projected outwards on to his objects and later re-introjected into a split self in a way that often resists therapeutic efforts.

Example: "I hate myself"

Anna, a 29-year-old married woman, had felt there was something "wrong" with her since she was at least 14, when she entered a sexually abusive relationship with an older man. She disliked her body, which she saw as both fat and flat-chested, and had only really liked herself for the 6 months when she was breast-feeding her daughter, when she had a visible bosom. She had shown many aspects of psychological disturbance, including heavy drinking, anorexia, considerable cannabis use, and increasingly determined episodes of self-harm in which she took tablets and cut or burned her face, legs, arms, and genitals. She "knew" that she was "rotten" and "hateful", and kept a secret diary of poems in which she recorded her self-hatred. When Anna was 10, her mother, on whom she was very dependent, began an affair of which Anna was aware, often seeing the lovers kiss and hearing them make love. Anna felt utterly abandoned and desperate, furious with her mother but unable to say anything for fear of betraying her to her father. It was at this point that she began to experience self-hatred, which seemed to be based on an identification with her feelings towards her mother – her "absent" and "invisible" breasts symbolising her feelings of abandonment. Despite numerous therapeutic efforts, this core belief in herself as "bad" persisted through Anna's very stormy early course of treatment, and she seemed almost to take pleasure in her ability to thwart those trying to help her, including the analyst. She would regularly harm herself whenever she felt there was some possibility of progress in therapy. The only escape from it seemed to be when she felt numb – as she put it: "Not bad, but nothing". This adaptation to managing her torment had kept her alive, but left her stuck.

In this situation, the analyst decided on a high-risk approach, by questioning whether the analysis should continue. He thus challenged her terror of change, focusing on the battle being played out between them, pointing out how progress was undone, leaving them at loggerheads. Once Anna felt that her analyst could understand the

necessity for this dynamic as a survival strategy, a rebuilding of her relationship with her body and subjective experience of self began to emerge, although painfully and with many setbacks.

This position of an identified internal "bad parent" object, who is clung to, and who punishes and persecutes in the way that the original "bad object" did in reality, combined with elements of revenge and triumph over the object, is a common constellation in BPD. One patient described this split-off identificate as "Him", an evil male who took over her personality and made her do destructive things.

Steiner (1993) describes the inner world of the borderline in spatial terms. Between the splitting of the paranoid–schizoid position and the pain of the depressive position lies the "borderline position". The sufferer seeks out "psychic retreats" – safe havens, free from pain, but also sequestered from real emotional contact with people and the flux of life. Steiner suggests that silent, aloof, over-talkative or pseudo-cooperative patients may be operating from such retreats, which are often symbolised in dreams as caves, fortresses, houses, or parts of the body. Fanatical affiliation to political or religious groups may have a similar defensive function as a way of containing disturbance, but also potentially impedes psychic growth.

Narcissistic personality disorder

Kernberg (1975) views NPD as a more mature but no less therapeutically problematic variant of BPO, in which there is a fusion between the ideal self and the actual self. Real intersubjectivity is obliterated in an attempt to avoid feelings of rage, disappointment, envy, contempt, and despair. Two types of narcissism have been distinguished. Rosenfeld (1987) writes of the "thick-skinned", oblivious, insensitive type of narcissist, obsessed with themselves and their achievements, whose relationships reflect the need to be admired, and lack depth or substance. By contrast, the hypervigilant "thin-skinned", over-sensitive, often hypochondriacal type of narcissist, whose emotional life is the subject of intense and constant scrutiny, is perhaps best seen as vulnerable to Winnicottian "impingement", due to a deficit of maternal attunement. This has significant ramifications for treatment in terms of psychoanalytic intervention (Bateman, 1998).

Deficit models

Deficit models, elucidated extensively by Kohut (1971, 1977), identify similar features of BPO, but tend to put a different emphasis on the clinical phenomena:

1. *Aggression.* For Kernberg, excess aggression is the primary abnormality in BPO. For Kohut and Fairbairn, the aggression is secondary to environmental failure, a protest against an unresponsive mother, or a way of holding on to an object through hatred in the absence of the capacity to love. The fragmentation and inner loneliness of the borderline patient are seen not as defences, but as "breakdown products" of an individual deprived of vital supplies of love (Adler, 1985).
2. *The ego.* Conflict theorists see the ego as "weak" and unable to contain aggressive impulses. Deficit theorists emphasise the failure of self-soothing function often found in BPO. Unable to calm themselves psychologically, patients with BPD turn to dependent relationships with others, drug use, compulsive sex, binge-eating, or self-harm. Thus, many "cutters" describe escalating agitation that, at the moment of self-injury, turns into an almost post-orgasmic sense of calm.
3. *The role of the environment.* Kohut and Winnicott have a rather idealised view of the early mother–infant relationship, in which the mother's responsiveness and attunement, her capacity to foster transitional space and to supply "self-object" needs, leads to a secure, stable sense of self. Where the basic "good enough" maternal functions were missing, the child is vulnerable to BPD in later life.
4. *The necessity of narcissism.* For Kernberg, the narcissist is in a state of conflict between the need for an object and the rage felt towards his objects – hence, obliterating the gap and self-absorbedly "becoming" one's ideal self. For Kohut and Winnicott, the narcissist is faced by an insensitive, absent, or abusive primary object, and so retreats into him/herself, trying vainly to "be" the missing mother so desperately needed, to preserve some sense of inner coherence.

Winnicott (1965) also argued that borderline patients employ a number of the same defences as psychotic patients. He notes that these patients have no sense that others – including the therapist – have lives of their own. Such patients respond with intense anger if their sense of omnipotence is threatened. These observations have been partially confirmed by research showing that BPD patients have a specific deficit in mental-state awareness (i.e., mentalising) in the context of attachment relationships (Fonagy & Target, 1996).

Winnicott, and object relational formulations more generally, did not completely reject the role of constitutional factors in psychopathology, but they have often exclusively emphasised the role of the early environment. Such an emphasis is inconsistent with the results of more recent behavioural genetic studies (Plomin & McGuffin, 2003). By contrast, the neo-Freudian tradition showed greater respect for constitutional factors and the role of genetics in symptom choice and vulnerability to environmental stress. Research on the genetics of personality disorders in general has in fact

shown that they are highly heritable (Bornovalova, Hicks, Iacono, & McGue, 2009; Distel et al., 2008; Kendler et al., 2008; Torgersen et al., 2008).

The major weakness of Winnicott's theory in terms of the developmental origins of BPD – which the British object-relations tradition partially shares – is its simplistic model of infancy, leading to metaphorical descriptions that, however clinically useful, fail to do justice to the complexity of psychological development. In the face of the evidence (Rutter, Kim-Cohen, & Maughan, 2006), the argument for a linear development from infancy to adulthood cannot be maintained. Human development is too complex for experiences in infancy to have direct one-to-one links to personality pathology in adulthood. Longitudinal studies have suggested that personality is subject to reorganisation throughout development, based on significant positive and negative influences (Lyons-Ruth & Jacobvitz, 2008; Lyons-Ruth, Yellin, Melnick, & Atwood, 2005).

Taking into account this new evidence from developmental research, more recent psychoanalytically informed reformulations of BPD are more nuanced. One such theory, based on mentalising, integrates understanding from neurobiology, psychoanalysis, attachment research, and cognitive development (Bateman & Fonagy, 2004; Fonagy, 2000). This model has led to a psychoanalytically based treatment with a strong evidence base (see Chapter 11). The mentalising theory of BPD is rooted in Bowlby's attachment theory and its elaboration by contemporary developmental psychologists. While paying attention to constitutional and neurobiological vulnerabilities, it combines evidence from different scientific disciplines.

Mentalising develops in the context of, and is loosely coupled to, attachment development. There is evidence that borderline patients have a history of disrupted and disorganised attachments in childhood, which lead to problems in affect regulation, interpersonal and social function, attention, and self-control (Lyons-Ruth et al., 2005; Sroufe, Egeland, Carlson, & Collins, 2005), all of which are at the core of BPD (Bateman & Fonagy, 2010, 2016). These problems are mediated through a failure to develop a robust mentalising capacity that is resilient to stressors, in particular attachment stressors (Fonagy & Luyten, 2016). Given the known continuity of attachment styles over time, residues of attachment problems of childhood might be expected to be apparent in adulthood.

Levy, Meehan, and Hill (2005) reviewed a series of studies investigating attachment patterns and BPD. BPD is strongly associated first with insecure attachment (only 6%–8% of BPD patients are coded as securely attached), with indications of disorganisation as a subcategory, and second with fearful-avoidant and preoccupied attachment. Summarising across several studies, it appears that early attachment insecurity is a relatively stable characteristic of the individual, particularly in conjunction with subsequent negative life events (Hamilton, 2000; Waters, Merrick, Treboux, Crowell, &

Albersheim, 2000; Weinfield, Sroufe, & Egeland, 2000). Given evidence of the continuity of attachment from early childhood, especially in adverse environments, the extent to which childhood attachment may affect mentalising is relevant to the development of BPD. The quality of children's primary attachment relationship has been shown in a number of studies to predict mentalising ability, especially the link with the emotional understanding aspects of mentalising (Ensink, Begin, Normandin, & Fonagy, 2016; Hayden, Mullauer, Gaugeler, Senft, & Andreas, 2019; Sharp, Fonagy, & Allen, 2012). Overall, it seems likely that this attachment–mentalising relationship is mediated within a family via the coherence and mentalising nature of the general discourse in the home. Certainly, there is considerable evidence to suggest links between the family environment and the genesis of a number of mental disorders, especially BPD (Zanarini et al., 2000).

The breadth of these models and their contrasting emphases can be confusing for the clinician. But there is consensus around the importance of developmental trauma as being a major factor in the aetiology of BPD, and increasing evidence for the impact of severe environmental disruption in the childhoods of BPD patients. A number of studies report that up to 90% or even more of patients with BPD have experienced some form of abuse or neglect in childhood (Ball & Links, 2009; Chanen & Kaess, 2012). BPD patients have been found to be four times as likely to have suffered early trauma as normal controls (Johnson, Cohen, Dohrenwend, Link, & Brook, 1999) and have higher rates of childhood maltreatment than people with any other personality disorder (Baird, Veague, & Rabbitt, 2005; Buchheim et al., 2008). As an aside, the increasing evidence of child abuse in the histories of BPD throws doubt on the early psychoanalytic focus on "pre-oedipal" years in these patients, since abuse occurs most frequently in latency and early adolescence.

Therapeutic strategies

As with psychosis, these theoretical differences are reflected in differing treatment strategies. Kernberg and the Kleinian schools tend to emphasise the importance of verbal interventions and the need for early interpretation of negative transference, while the deficit group sees the creation of a holding environment through empathic responsiveness and validation as the prime necessity. Conflict theorists are concerned about creating a collusive relationship in which real aggression is denied, mirroring the maternal deprivation in childhood that led to the development of a false self and the inhibition of autonomy and exploration. Deficit theorists believe that too much emphasis on negative transference weakens the already fragile self-esteem of the borderline individual, and even creates the very aggression it attempts to interpret (Ryle, 1994).

Each approach in pure culture can lead the analyst into serious difficulties of over- or under-involvement. An overly protective and empathic strategy can lead to regressive dependency, escalating demands, and erotic transference, with the therapist shifting abruptly from over-involvement to attempts to distance using interpretation followed by frank rejection.

Example: Too close, too soon

A nurse in her early twenties was seen for assessment. She had a history of self-harm, mood swings, unstable relationships, and alcohol abuse. She had felt utterly neglected by her mother when a much favoured younger brother was born, and was sexually abused by her father between the ages of 11 and 14. She telephoned the day after the assessment, demanding to be taken on immediately, and treatment was hurriedly organised with an inexperienced male therapist. After a few sessions, she stated that words were not enough, and requested to sit near the therapist so that she could "feel the closeness I longed for but never had with my mother". Her request was granted, but she then insisted that he stroke her hair, which again he naively agreed to do. Like the fisherman's wife in the fairy story, she next stated that 50 minutes was not nearly long enough. When the therapist explained that he could not extend the sessions, but that she could remain behind for a few minutes to compose herself if she wanted, she barred his way out of the consulting room. The end of each session came to consist of a "wrestling" match as he tried to extricate himself from the room. The therapist attempted to interpret these events as a repetition, via projective identification, of her intense jealousy of her therapeutic "siblings" waiting to be seen after her session was over, and the feelings of claustrophobia she felt during the sexual abuse, but to no avail. The therapy came to a dramatic and catastrophic close, and the patient, who was seen again by the original assessor, was offered a more supportive therapy with an experienced therapist.

The problems created by more confrontational tactics may be less dramatic and, as Kernberg (1984) states, "It is easier to move from expressive to supportive therapy than in the other direction", but if used insensitively they cause many dropouts in therapies that might otherwise have progressed, since patients with BPD often find silence and negative interpretations confusing and unbearable. In a systematic analysis of dropouts in a range of therapies for BPD (Barnicot, Katsakou, Marougka, & Priebe, 2011), less emotional communication during treatment and a poor therapeutic alliance predicted dropout, as did high levels of patient interpersonal avoidance, trait

anxiety, and high levels of anger; these factors may be ameliorated using an integrated supportive–exploratory approach rather than rigid adherence to one model.

Again, these differences may be more important as ideological rallying cries than as clinical guidelines. All would agree that establishing a sound therapeutic alliance is both essential and extremely difficult. The interpretation of negative transference and a high degree of acceptance and holding may, in varying circumstances, be appropriate. Containment and acceptance are equally important. The patient, lacking the capacity for self-soothing, needs gentleness; but important too is the therapist's freedom to confront a constantly projected inner world, held in the grip of bad objects. Fosshage (1994) relates treatment in BPD to Gedo and Goldberg's (1973) developmental sequence of empathy, moving from physiological regulation in the newborn, through attunement in infancy, to "consensual (i.e., verbal) validation" and limit-setting in the toddler. He argues that to mobilise analysable transference in BPD some non-interpretive work is required: because such patients are operating at a developmentally pre-verbal level, this in BPD is still "analysis", whereas with higher-functioning individuals it would not be.

Recognition that some patients with BPD are fragile and have only a precarious ability to sustain therapeutic relationships is necessary, as there are those who may need to feel utterly secure with their therapist, to be reassured that they can make contact in emergencies, and to be offered special arrangements during breaks, such as a "backup" therapist and being sent postcards from their therapist when on leave. Some of this subgroup of patients may be treated in hospital as either inpatients or day patients, where the holding environment is already in place, but this is rare nowadays, with patients with BPD being treated in outpatient settings in most countries. Interventions that help patients with BPD to face up to their destructiveness, although challenging, may also be an enormous relief, representing a small first step towards the realisation that they can master their misery from within, rather than constantly blaming circumstances or other people.

In summary, the following is a list of the essential conditions that are now generally accepted for successful analytic work with patients with BPD:

1. A stable treatment framework that safeguards the integrity of the patient, the therapist, and the analysis. The therapist needs to recognise that some patients will not be able to tolerate strict analytic boundaries, and will have to make themselves more available than is conventionally recommended.
2. An initial phase that carefully incorporates supportive techniques so that interpersonal anxiety is tolerated, with the development of a therapeutic alliance that can withstand ruptures. This phase may require the patient and therapist to sit face-to-face initially.

3. Limit-setting. The counterpart of condition 1 is the need for clear boundaries and to ensure that the patient understands them. For example, one patient was allowed to contact her analyst between sessions once per week, but if she contacted the analyst more often than that, then a session was forfeited the following week.
4. Interpretive focus on the here-and-now rather than reconstruction using genetic interpretation. Minute-by-minute microfailures of empathy will inevitably occur, and will be responded to by the patient with withdrawal and/or paranoid feelings of being abandoned, toyed with, or even tortured. These need to be focused on within the session as they arise. Similarly, the patient's inevitable feelings of hatred and rejection towards the therapist need to be taken up, so that good and bad imagos can be gradually reconciled – the "good" attentive analyst listens to how horrible and "bad" the patient feels he is.
5. Constant monitoring of countertransference. As the examples given earlier in this chapter suggest, extensive use of projective identification means that countertransference is a key therapeutic tool in BPD. The therapist will be cast in the role of both rescuer and attacker, and must be able to "treat those two imposters just the same", and when the inevitable therapeutic mistakes and muddles occur, to disentangle his own contributions from those of the patient. His overall stance – whether he is a follower of the ideas of Kernberg, Winnicott, or Kohut – is likely to be, at least in part, a product of his own unconscious needs and experiences, producing, respectively, a punitive or an indulgent attitude towards vulnerability. This will need to be examined through both personal analysis and vigilant self-scrutiny.
6. Avoidance of a passive therapeutic stance. "Classical" silence and complete non-directiveness may produce unbearable anxiety for the patient with BPD. Most analysts will admit to "breaking the rules" (Steiner, 1993) and often include more supportive elements, such as reassurance, analytic transparency, and guidance, than they would with less disturbed patients.
7. Containment and confrontation of anger and self-destructiveness. Angry outbursts or self-destructive behaviour will almost inevitably arise in the course of an analytic treatment of a patient with BPD. These need to be handled firmly but non-punitively. The therapist should not react in the heat of the moment but "strike when the iron is warm". Analysts may be confronted by patients who arrive at sessions drunk, or having cut their wrists or taken an overdose. They may be subjected to unrestrained wailing or screaming in sessions, or intrusions into their private lives. Clear guidelines or even a contract may be needed to keep this behaviour within manageable bounds. Such patients may need to have it firmly stated that while everything possible will be done to try to prevent them from harming or even killing themselves, the ultimate

responsibility lies with them, not with the therapist. Contracts around self-destructiveness are best handled in cooperation with the patient's general medical practitioner, psychiatrist with access to inpatient beds, social worker, and/or spouse, using a collaborative and consistent approach.

8. Therapeutic focus on the connection between feelings and actions. In addition to the limit-setting mentioned in conditions 3 and 7, the therapist must, through minute reconstruction of the events in the inner world leading up to episodes of aggression or despair, help the patient to identify the thoughts and feelings associated with destructive actions.
9. In summary, progress in treatment will be shown within sessions by all or some of the following: (a) the capacity to expand on the analyst's comments; (b) tolerance of phantasy – including hatred and eroticism – as opposed to behaviourally communicated distress; (c) tolerance of interpretations directed at grandiosity and projective identification; and (d) the capacity to experience guilt as a pointer to the impact their actions and words can have on others.

The complex patient: hospital treatment in borderline personality disorder

Sooner or later the analyst may be faced with the need to admit a patient with severe BPD into hospital or a crisis house. Such admissions should be brief rather than prolonged. There is little evidence for the benefits of long-term inpatient treatment compared with outpatient interventions, although extended inpatient treatment of around 40 days can result in significant and clinically meaningful symptomatic and functional improvement in BPD patients, without iatrogenic effects (Fowler et al., 2018). Nevertheless, Paris (2017) strongly advises against long-term hospitalisation, concluding that hospital admissions are designed to treat episodic mood disorders and psychosis as conditions in their own right, but not persistent mood or suicidal conditions associated with BPD. However, the evidence suggests that the picture is not so clear-cut. Vermote et al. (2009) identified four different treatment–outcome trajectories of patients admitted to a specialist ward for inpatient psychoanalytic treatment. These four trajectories related to pre-existing personality styles. Patients with characteristics of self-preoccupation and identity difficulties did better with a predominantly insight-oriented programme and were less likely to drop out than those with more externalising symptoms, paranoid mechanisms, or a predominantly interpersonal focus to their difficulties. The latter group may have responded more favourably to an increase in supportive work and a reduction in insight-oriented interventions. So, the question may be more about the focus of a psychoanalytic programme – the conflict/deficit debate in another form – than about who might benefit from inpatient psychoanalytic treatment. Whatever

the merits of longer psychoanalytic inpatient treatment, brief crisis admissions can be very useful to help patients over difficult moments in their lives or treatment. Here, the hospital acts as a temporary haven, auxiliary ego, container, or "self-object", freeing the analyst to continue with interpretive work.

Example: Rationing hospital admissions

A very anxious woman in her early twenties showed high-risk behaviours during each weekend break – climbing dangerous scaffolding, getting drunk, and entering into risky sexual situations with men she hardly knew. She often self-presented or was brought to the hospital emergency department by the police in the middle of the night. By Monday morning she would have "forgotten" these episodes or attributed them to "Him", one of her subpersonalities/alters. Her diagnosis was multiple personality disorder (in which BPO is very evident). Once it was established that it was she – her central self – who felt abandoned, helpless, and desperate when she could not see her analyst, a contract was drawn up between the analyst, the local psychiatric service, and the patient, offering her automatic rights of access to a hospital bed for the weekend up to twice per month. She used this facility only rarely, and eventually found a sympathetic general practitioner who supported her when the analyst was not available.

In some countries, psychoanalytically informed day-hospital treatment is available to people with BPD rather than inpatient treatment, particularly if they are a high risk, have serious social problems, and have comorbidities such as severe depression or substance abuse. The initial studies on mentalisation-based treatment, which reported on the outcomes of patients treated in a partial hospital programme compared with patients receiving "treatment as usual" (outpatient/community/inpatient care), found significant benefits from the partial hospital intervention (see Chapter 11) (Bateman & Fonagy, 1999). Subsequent studies of day-hospital treatment have confirmed some short-term benefits of this context for treatment (Smits et al., 2020).

Affective processes

In Chapter 1, we suggested that *affect* has replaced instinct, impulse, and libido as the central theme in psychoanalytic thinking. Anxiety and depression are undoubtedly the most common of all the painful affects that lead patients to seek psychoanalytic help. Anxiety and depression are

common in most if not all psychological disorders, at all levels of severity. As with psychotic and borderline processes, psychoanalytic understanding of affective disorders does not map directly on to specific psychiatric diagnoses. In what follows, we look at the relationship between anxiety and depression as conceived psychoanalytically, and their manifestations in psychiatric disorders.

Anxiety

Freud's (1926) volume *Inhibitions, Symptoms and Anxiety,* published in his 70th year, marked an important shift in his thinking. His earlier idea about anxiety was that it represented "unbound" psychic energy or libido that had escaped the forces of repression. This is still a useful way of looking at the overwhelming waves of anxiety that survivors of disasters and other traumata often feel (Garland, 2002; Holmes, 2020). But, once the structural model (see Chapter 2) was in place, he began to conceive of anxiety as an *adaptive* response of the ego, and a stimulus to psychological or behavioural action. "Signal anxiety" arises when there is a conflict between different parts of the "psychic apparatus". This leads to conceiving of a hierarchy of different types of anxiety, depending on where the conflict predominantly lies.

Superego anxiety

Here, the conflict lies between the ego ideal, with its guardian conscience, and the actual performance of the ego. People with perfectionistic obsessional characters worry constantly about their inability to achieve the high standards they set themselves. Behind this may lie a sense of a demanding internal parent who cannot be satisfied. Since anxiety and aggression are often inversely related, superego anxiety may contain a fear of a retaliatory punishment for these overwhelming demands, itself a projection and re-introjection of the patient's own demanding neediness.

Castration anxiety

The analysis of male impotence was the counterpart of Freud's early focus on female hysteria (Mitchell, 1988). Freud understood "castration anxiety" in terms of the oedipal fear of the little boy that his punishment for loving his mother, and so challenging his father, would be "castration", and consequent relegation to what he presumes to be the position of women. While "Oedipus" is no longer thought of so literally in bodily terms, castration anxiety as a sense of powerlessness within a phallocentric society is an important theme in feminist-influenced thought (Benjamin, 1988; Chodorow, 1978) and so applies as much to women as men. "Fear of success", difficulty

with assertion, and sexual inhibition can also be understood within the rubric of castration anxiety. In Kleinian terminology, "castration anxiety" can be related to depressive-position feelings of having damaged the object and so harbouring a wound within oneself.

Separation anxiety

Bowlby (1988; discussed further by Holmes, 2013) expanded on Freud's idea that a fundamental conflict in neurotic disorders was that between the need for an object and the concomitant fear of losing the object. Constantly seeking approval, over-dependency, agoraphobia – or, conversely, excessive detachment (if one does not have an object, one does not risk losing it) – can be understood in terms of both separation anxiety and defences against it. Bowlby saw separation anxiety as a response to real parental inconsistency or absence in childhood, leading to clinging and fearful behaviour in the victim, whose fears of being abandoned are realistic. The normal response in securely attached children to separation from their caregivers is angry protest, which typically motivates the caregiver to re-establish a secure base and leads to gentle soothing. In anxiety disorders, where this mutual resonance is compromised, implicit aggression often plays an important part in the dynamic.

Example: A fugitive from injustice

Peter was a 40-year-old headmaster of a secondary school who was experiencing escalating anxiety. One day he left work as usual but, instead of going home, booked himself into a hotel in a neighbouring town, staying in his room for two days without informing anyone where he was. Eventually, he phoned the local psychiatric hospital and, following a brief admission, was referred for psychoanalysis. The precipitant of his "fugue" was what he saw as the increasing bureaucratic demands that government-imposed changes in the teaching profession placed on him. He had been a model and successful teacher, but had felt increasingly anxious, frustrated, angry, and guilty – feelings he had kept to himself.

He was the younger, by 10 years, of two sons. When his older brother was killed in a climbing accident at the age of 19, Peter's mother became intensely anxious, and found it harder and harder to allow Peter to do the normal adventurous things a 9-year-old wanted to do. Peter became adept at placating her, but was left with a feeling of always being second best, and having to look after his own emotional needs. At times, he was similarly polite but subtly

controlling and distant in therapy, inducing mild feelings of guilt in the therapist that he was never quite giving enough.

Peter's anxiety-driven fugue could be understood in part as a replaying of his brother's loss; a way of testing whether his wife (who had become very engrossed in a business she had started only recently) really wanted, and cared about, him; a revenge on the educational system that had ensnared him and taken him for granted; and, indirectly, an attack on the mother on whom he depended (and who depended on him) but with whom he also felt furiously angry for the inhibitions she had imposed on him.

Persecutory anxiety and disintegration anxiety

Psychotic types of anxiety in which the sufferer projects his own feelings of hatred and envy, and then feels persecuted by these feelings, which he attributes to others, have already been discussed. Disintegration anxiety is also part of the more psychotic picture discussed earlier, and reflects the "primitive" fears of fragmentation and annihilation experienced in some psychotic states or, as Winnicott (1965) puts it in his paper *Fear of Breakdown*, "falling forever".

Treatment

As the above-mentioned types of anxiety imply, there is no single psychodynamic formulation or interpretive method that applies to all anxiety disorders. The consistency of the analytic setting is often enough to counteract the crippling effects of separation anxiety. The techniques described in the preceding two chapters – working from anxiety to defence to underlying feeling or impulse – form the basic clinical strategy needed in approaching anxiety. The anxious patient will test the analyst's ability to orient the treatment along the expressive–supportive spectrum (Wallerstein, 1986). There will inevitably be overt or unconscious pressure for reassurance and support. As mentioned earlier, the research evidence suggests that personality characteristics might be one of the factors determining whether a patient benefits more from a supportive than an interpretive approach, with psychologically sophisticated patients using mature defences doing better with a more strictly expressive mode of treatment (Vermote et al., 2009).

In the current psycho-political climate in the United Kingdom, anxiety disorders are typically seen as the preserve of cognitive-behavioural therapy (CBT). However, Milrod, Busch, Cooper, and Shapiro (1997) have developed a psychodynamic therapy model for anxiety, concentrating particularly on the avoidance and denial of anger. This model has shown good

outcomes in a 24-session psychodynamic therapy compared with controls, sustained over 6 months of follow-up (a short period, but comparable to the evidence base for CBT) (Milrod et al., 2001).

Depression

Psychoanalytic theories about depression centre around the themes of (a) ambivalence around aggression, (b) loss, and (c) self-esteem. Freud initially saw depression in terms of a conflict model, picturing a regression to the cannibalistic "oral stage" of development in which the sufferer experiences ambivalent guilt at having destroyed the very object he loves. This would explain the anxious dependence that is often a feature of depression.

However, stimulated by discussions with Abraham, Freud (1917), in his famous paper *Mourning and Melancholia*, suggested that loss was a central precipitant and precursor (i.e., vulnerability factor) in depression. A triggering current loss reawakens earlier childhood losses – actual or symbolic – and, through "identification with the lost object", the sufferer attacks himself with reproaches that rightly belong to the loved one who has left him or let him down. Freud saw depression as a "narcissistic disorder" because of this withdrawal from the object into oneself.

Klein (1975) used these ideas in her model of psychological development, in which external loss – of the breast, the exclusive preoccupation of one's mother, or the admiration of the father – is compensated by the establishment of an internal world into which the lost external object is "reinstated". She saw the successful achievement of the depressive position in childhood as immunising the individual against loss in later life and, conversely, that individuals with depression are thrown back to earlier failures to integrate good and bad into whole objects in the inner world. People with depression believe themselves omnipotently to be responsible for their losses, due to their inherent destructiveness, which has not been integrated with loving feelings. The sado-masochistic element in depression – attacking oneself, and thus vicariously attacking one's loved ones through one's misery – arises from projection and re-introjection of these feelings of envy and hatred. For Winnicott (1965), if the depressive position – or stage of concern – has been achieved, the reaction to loss is grief; if not, the reaction is depression.

Pedder (1982) relates these Kleinian ideas to the psychosocial findings of Brown and Harris (1978) (the latter a distinguished psychoanalytic psychotherapist as well as a researcher) in depression, which confirm the role of childhood loss, especially of the mother through death, divorce, or neglect, as a major vulnerability factor. Brown and Harris see loss of self-esteem as central to the psychology of depression. For Pedder, self-esteem implies an internal object relationship in which one part of the self is "held" lovingly by another. If this structure has not been achieved – that is, if, in Kleinian terms, the depressive position has not been reached – individuals will depend

excessively on external sources of positive regard, and if these are lost due to the vagaries of fortune, they will be vulnerable to depression.

Treatment

Psychoanalysis is rarely a first-line treatment in severe clinical depression, although interpersonal therapy (IPT), a form of brief psychoanalytically informed psychotherapy, has been shown to be effective in depressive disorder (Elkin et al., 1989; Klerman, Weissman, Rounsaville, & Chevron, 1984). A number of evidence-based psychodynamic treatments have now been developed for milder and more chronic forms of depression. In general, brief psychoanalytic psychotherapies are as effective CBT, IPT, or antidepressants (Leichsenring, Rabung, & Leibing, 2004). An example is dynamic interpersonal therapy (DIT) (Lemma, Target, & Fonagy, 2011), which concentrates on the interpersonal aspects of depression: how recent losses trigger traumatic memories of early childhood separations; how these may be reactivated in therapy (transference reactions to therapists' absences); and fostering the capacity to think about (i.e., to mentalise) negative affects rather than being overwhelmed by them.

Some patients with chronic depression can be treated psychoanalytically, although, as with all treatments for this often very long-term condition, the results are variable. The Tavistock Adult Depression Study (Fonagy et al., 2015; Taylor, 2015; Taylor et al., 2012) compared the outcomes of 18 months of psychoanalytic psychotherapy with treatment as usual (i.e., antidepressants and supportive management), and showed significantly better outcomes for the psychoanalytic treatment group. An important aspect was that the psychoanalytic treatment group continued to improve at 2-year follow-up relative to the group receiving treatment as usual (see also Chapter 11).

The basic therapeutic strategies in the psychoanalytic approach to depression include mobilising repressed aggression; working through unmourned losses; externalising and understanding internal sado-masochistic patterns in the transference; neutralising excessive superego demands; and providing a secure base that is neither clung to nor shunned.

The analyst will inevitably experience times of despair, rage, and hopelessness in working with these patients. Winnicott (1965) saw that the boundaries of therapy – 50-minute hours, breaks, and holidays – express the analyst's countertransferential "hate" and parallel those of the "good-enough" parents who put their child to bed and attend to their own needs. This insight is particularly relevant to working with chronic depression. Strachey's model of mutative factors in psychoanalysis (see Chapter 8) suggests that patients project their own hopelessness and hatred into the analyst, who, combining continuing concern with warm limit-setting, disconfirms the vicious circle of depression. This enables patients to feel safer

about expressing aggression – as Winnicott (1969) vividly puts it, like a child both playful and furious: "Hello object! I destroyed you" – and to integrate these feelings with positive ones and so gradually to build up a more benign set of internal objects.

Example: A death as a new beginning

Nancy had had depression since her teens and, while at university, had made a major suicide attempt and been admitted to a psychiatric hospital for 18 months. She was the younger of two sisters; her mother had had a severe postpartum depression following a stillbirth and had herself been in hospital for 9 months when Nancy was about 3 years old. Nancy had been looked after by her father, whom she grew to detest; in the course of analysis, she began to believe that his care at that time was severely defective or even abusive. Her parents owned a bar; she experienced her mother as intrusively offering the "affection-less control" that is often a feature of depression.

Throughout her twenties and thirties, she had lived the life of a semi-invalid, restricting her social life, plagued with overwhelming feelings of rage and despair, spending large parts of the day in bed, and working only very intermittently in her job as a librarian. Her first marriage had foundered; in her second she had married an older man who was immensely tolerant and who appeared to be immune to her violent verbal attacks and enormous dependency. She entered analysis after the birth of her son, fearful that without help she might not be able to manage motherhood.

The first 4 years of analysis seemed to produce little benefit other than, perhaps, stabilising her life and providing a container for her aggression and dependency. She would at times launch into a vicious attack on the analyst, whom she saw as a superior, heartless treatment machine on whom she had become inextricably dependent, and whose sole purpose was to humiliate her. The sessions were often silent, repetitive, and static, leaving the analyst feeling trapped and impotent, although in her less furious moments she confessed that she did value the treatment since, apart from her husband, the analyst was the only person in the world to whom she could express her hatred. On two or three occasions, she required brief hospitalisation when her depression became overwhelming, but this too served only to remind her of her hopelessness and inability to cope.

Then, suddenly, her husband became ill and, after a period of illness in which she nursed him magnificently, died. The 2 years following his death saw a remarkable transformation in Nancy. She grieved greatly, but at the same time her confidence increased; she

began to think of herself as normal rather than an alien creature; she started to enjoy her son and her friends; she began to travel, venturing into territory that she would have avoided in her previously restricted life. She made a partial reconciliation with her parents, from whom she had completely cut herself off. Eventually, she met another man with whom she developed a much more equal relationship and with whom she could, when necessary, argue in a productive and mature way, compared with her previous dependent destructiveness.

In parallel with these external changes, the analysis became far less static, and a warm relationship began to develop. Breaks, which previously had often led to breakdown, were tolerated without mishap. Interpretations, almost for the first time, seemed to be meaningful to her. The analyst began to feel more like a real person in the sessions rather than a vague object that she attacked, or from whom she gained some frail warmth.

Nancy's analysis was one of those in which change was gradual, with no virtuoso breakthrough interpretations or overwhelming mutative moments. Perhaps the most important contribution was that the analyst continued to "be there", and survived her vicious attacks without retaliation. He was both challenging and tolerant of Nancy's need for physical as well as psychic retreat, however much she tried to provoke him into telling her she had had enough, should get a job, had no right to sleep every afternoon, was not fit to be a mother, and so on.

Presumably on the basis of an introjective identification with this analytic function, after bereavement, Nancy seemed to take on more and more of the positive qualities of her dead husband. She said that she felt that he was inside her, and that she was drawing strength from his guidance. When faced with difficulty, she would ask herself what he would have done, and it was usually right! He became the "good object" who, although physically absent, had at a psychological level survived her attacks. He had, in Klein's word, been "reinstated" within her. Her inner world was, for the first time in her life, secure. She was amazed to discover, after 8 years of analysis, that she was finally free of dependence.

Although this case has been presented at some length as an example of affective processes, it illustrates how psychotic, borderline, and affective aspects are layered within the personality, all of which need to be addressed in the course of analysis. At times, Nancy developed a psychotic transference in which she projectively saw the analyst as a mocking persecutor, cruelly toying with her like a cat with a baby bird. There were many

"borderline" features, including her feelings of emptiness and boredom, and explosive rage, all of which seemed to revolve around a defect of self-soothing. Her low self-esteem and avoidance of competition with other women were examples of more neurotic aspects. The identification and timing of interventions addressing these different layers is one of the most important aspects of the craft of psychoanalysis – whose exposition has been one of the aims of this book.

Conclusion

In this chapter, we have tried to show how psychoanalysis can make a significant contribution to mainstream psychiatry in three main areas. First, it has much to offer in developing diagnosis-specific therapies, particularly in the domain of complex personality disorder. Second, it enables psychiatrists to understand the transferential and countertransferential thoughts, feelings, and enactments aroused by their clinical work, thereby helping to avoid the ever-present iatrogenic dangers implicit in psychiatric practice. Third, through gaining greater understanding of the nuances of the therapeutic relationship, psychoanalytically informed and oriented psychiatrists can empathise and communicate effectively with their patients, even when the focus of treatment is not primarily psychodynamic. Eisenberg's (1986) famous trope that psychiatry should be neither brainless nor mindless remains valid. We hold to the view that, alongside the new brain science, psychoanalysis continues to offer the most comprehensive clinical account of the mind and its disorders currently available.

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Chapter 11

Research in psychoanalysis

> In psychoanalysis there has existed from the very first an inseparable bond between cure and research. (Freud, 1926, p. 256)

Many years ago, subjected to professorial inquisition about his research output in a job interview at a famous postgraduate teaching hospital, a prominent analyst explained, "But each time I take on a new patient, that constitutes a fresh research project". As the quotation from Freud implies, his riposte was consistent with analytic tradition – but contained in that exchange was a clash of cultures highlighting the troubled relationship between psychoanalysis and contemporary science. It is a clash that to some extent has been lessened but, as we shall discuss, tension remains. Freud had a 19th-century conception of research: the intensive and disinterested study of phenomena. Building on Freud's pioneering ideas, leading psychoanalytic thinkers have continued to make conceptual and practical advances. But developments in the philosophy and technology of science have meant that contemporary understanding of the term "research" has acquired a specialised meaning, with an emphasis on measurement, the rigorous use of controls, statistical manipulation of data available to the wider scientific community, and replicability. If, as we suggested in Chapter 1, psychoanalysis is as much a craft as a science, then its findings, while clinically valuable, do not by contemporary standards in themselves constitute a body of scientific knowledge.

Psychoanalysis's difficulty in meeting the requirements of the current scientific paradigm flows from its reliance on the case history as a basis for its theorising. As Fonagy (1993, p. 577) put it, "evidence-based medicine" became the dominant paradigm:

> Its almost unique emphasis on anecdotal clinical data, however, left the epistemology of psychoanalysis and psychotherapy dependent on an outmoded epistemic paradigm: enumerative inductivism [i.e., generalising from a number of examples]. Enumerative inductivism, finding

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> examples consistent with a proposition, is at most an educational device and not a method of scientific scrutiny...The almost universal application of this epistemic tool in psychoanalytic writings [including in this volume! – *Authors*] has created a situation where currently, psychoanalysis has no method of discarding ideas once they have been proposed and made to sound plausible.

A "case history" is a sophisticated creation, in which the events of a clinical encounter are variously filtered, shaped, tidied up, reflected upon, romanticised, condensed, and generally tailored to fit theoretical preconceptions, in ways that make it highly unreliable (and unreplicable) as a source of information about what actually happens between analyst and patient.

In this paradigm, the psychoanalytic method is the instrument of research, and the psychoanalyst the interpreter of the data. Inevitably, this falls far short of the standards usually required for acceptance within the scientific community (Fonagy & Wolpert, 1999). Meanwhile, for practising psychoanalysts the preoccupations of contemporary science seem largely irrelevant to their day-to-day experience. One psychoanalytic response to this seemingly unbridgeable gulf is to concede the territory of science altogether, arguing (as, ironically, does behaviourism) that the inner world with which psychoanalysis is concerned can be reached only by introspection, and so, like the arts, is inherently unresearchable (Steiner, 1985). Psychoanalysis becomes part of the humanities, in which psychoanalysis is a "hermeneutic" discipline (Gardner, 2019) agreeing that the attempt to find external validation for its truths is doomed to failure, and advocating instead the criteria of internal coherence and narrative plausibility as the basis for settling disputes (Spence, 1982).

But, from the early days of psychoanalysis, there have been those who have tried, with varying degrees of success, to overcome these practical and philosophical objections, starting with naturalistic "field studies" of psychoanalysis and moving gradually towards a more firm scientific footing, for example, to single-case design methodology (Moran & Fonagy, 1987). We believe that it is important for clinicians to be aware of this research for several reasons. First, because it links psychoanalysis with the wider scientific community and helps to break down its esoteric and inward-looking tendencies. Second, research can reassure clinicians that their work is indeed an effective and useful treatment for psychological distress. Third, research helps to sift fact from myth and so enables the psychoanalytic community to scrutinise and refine psychoanalysis in order to discard what is outmoded or unworkable, and to develop what is most valuable. Fourth, because if psychoanalysis is to survive as a respected form of therapy, it will be required to prove itself scientifically. Finally, by grounding psychoanalysis in reality, research acts as an antidote to the dangers of wildness or ossification.

Methodology

As with all science, research in psychoanalysis depends on the development of suitable techniques and methods. The central task of psychoanalytic research is to navigate a channel between the Scylla of the near-unmeasurability of the issues that really matter to psychoanalysts – meaning, phantasy, the minutiae of patient–analyst interaction – and the Charybdis of the triviality of much behavioural research.

Psychoanalytic research in general can be divided into *outcome studies*, looking at the results of psychoanalytic treatment, and *process research*, which, as its name implies, studies what goes on in the psychoanalytic process itself. *Process–outcome research* studies the relationship between the two. Sound psychoanalytic research inevitably involves the introduction of a third party into the analytic relationship – an "oedipal" procedure that in itself has unconscious reverberations. In outcome research, the researcher will administer questionnaires or interview patients before and after treatment. The most obvious technique of process research is the use of tape- or video-recorded sessions, which, either in their raw state or transcribed, can be studied by a neutral observer. This material can then be subjected to further research procedures. For example, therapist interventions can be classified by agreed criteria as transference interpretations, non-transference interpretations, reassurances, and so on, and the effect of these interventions on the process of the session can be studied; independent judges can be asked to make psychodynamic formulations based on their reading of the scripts, and these in turn can be looked at by a second set of independent judges and assessed for their inter-rater reliability (i.e., the level of agreement between the two judges) and their ability to predict outcome in therapy; and the narrative structure of the transcript can be studied, looking at its fluency or associative freedom.

Psychotherapy research and psychoanalysis

Research findings in psychoanalysis itself are relatively sparse and, of these, few are methodologically robust. There are many reasons for this dearth, including the prolonged and diverse nature of psychoanalytic treatments, the traditional reluctance of most analysts to subject themselves to scientific scrutiny, the problem of accumulating a sufficient number of analytic cases for statistical purposes, and the difficulty in operationalising the theoretical concepts of psychoanalysis. By contrast, the study of psychotherapy, most of which focuses on methodologically manageable brief treatments, has become an expanding field, some of which is relevant to psychoanalytic work, assuming findings from short- and long-term weekly psychoanalytic psychotherapy can be extended to psychoanalysis itself. Before looking specifically at psychoanalytic research, therefore, we shall survey some relevant general findings from psychotherapy research.

The effectiveness of psychotherapy

Eysenck (1952) initially threw down the gauntlet to psychotherapy researchers with his manipulation of Fenichel's data, which he claimed showed that patients in psychoanalysis improved no more than untreated controls. By the 1980s, this view had been conclusively refuted with several well-controlled studies and meta-analyses showing the effectiveness of psychotherapy compared with no-treatment control conditions (Lambert, 2013). Only 30% of people on waiting lists improve spontaneously, compared with the 70% of treated patients who benefit from psychotherapeutic treatment. In addition, the rate of improvement among "waiting-list controls" – that is, people waiting for treatment who are being monitored using the same measures as those in a treatment programme – is slower than for those in active treatment (Lambert, 2013; McNeilly & Howard, 2008). Howard, Kopta, Krause, and Orlinsky (1986) studied the "dose–effect curve" in psychotherapy and found that, in general, the more prolonged the treatment, the greater the benefit. However, this is a negative logarithmic curve, and the greatest demonstrable gains (which usually measure symptomatic, rather than dynamic, change) are concentrated in the early stages of therapy. Overall, it takes around eight sessions for 50% of clients to show reliable improvement, and 21 sessions for about 85% of clients to do so. "Recovery", a more stringent criterion, requires more treatment, with 50% of clients estimated to recover after 14 sessions and 70% needing over 20 sessions. This general finding in psychotherapy research has been translated into health policy in terms of third-party payments for psychotherapy sessions for depression and anxiety, with the least severely affected patients being offered fewer sessions than those whose symptoms are more severe. Patients who have personality difficulties need longer and more intensive treatment (Goddard, Wingrove, & Moran, 2015), and, in a meta-analysis, longer-term psychotherapy has been found to be superior to less intensive forms of psychotherapy in treating complex mental disorders (Leichsenring & Rabung, 2011).

Another important issue is the stability over time of improvements made in psychotherapy. However, reports of long-term follow-up of patients receiving psychodynamic therapy are also sparse. Nevertheless, several studies have shown that treatment gains in psychotherapy are maintained at long-term follow-up (Leichsenring, Abbass, Luyten, Hilsenroth, & Rabung, 2013; Smit et al., 2012), with some suggestions that these long-term outcomes are better than those from briefer treatments (Knekt et al., 2016), thus strengthening the case for prolonged treatments such as psychoanalysis for people with complex problems. However, in a report of a 10-year follow-up comparing long-term psychodynamic psychotherapy (one or two sessions per week) with psychoanalysis (four or five sessions per week), the differences in outcome in terms of symptomatic relief were not significant,

although psychoanalysis provided some additional benefits when personality and social functioning were taken into account (Lindfors et al., 2019).

The placebo problem in psychotherapy research

The fact that a patient benefits from a particular form of therapy says nothing about the particular aspect of the treatment that is helping. The "equivalence paradox" (Stiles, Barkham, Mellor-Clark, & Connell, 2008) in psychotherapy research arises from the finding that although there is a vast array of different therapeutic methods, none can be shown consistently to be more effective than any other. As Luborsky, Singer, and Luborsky (1975) famously put it, quoting Lewis Carroll's "dodo-bird verdict": "Everyone has won and all must have prizes". Frank (1988) explains the equivalence paradox on the basis of his triad of "common factors" in therapy: "re-moralisation", or the restoration of hope; the offering of a relationship with the therapist; and providing a rationale and a set of activities that suggest a pathway towards health. In psychoanalysis, these would include regular attendance at sessions; focus on dreams and phantasies; the use of free association; and the expression of uncovered feelings.

The use of "placebo" therapies – such as "clinical management" by non-psychotherapists or unstructured self-help groups – is an attempt to tease out the differential contributions of "common factors" and specific interventions (e.g., transference interpretations, for psychoanalysts, the "mutative" ingredient). When active therapy is compared with placebo therapy, the "effect sizes" of the active therapy (an effect size is the difference between the group mean for a particular measure of change in the treatment group compared with the control group) are generally smaller than when compared with waiting-list controls. In a meta-analysis of placebo-controlled trials of a range of brief dynamic psychotherapies, short-term psychodynamic psychotherapy showed large pre-treatment/post-treatment effect sizes, ranging from 0.8 for social function to 1.39 for target symptoms. These effects were stable, tended to increase at follow-up, indicating that improvements continued even after the end of therapy, and exceeded those of waiting-list controls and "treatment as usual" (TAU) (Leichsenring, Rabung, & Leibing, 2004).

"Common factors" appear to produce effect sizes of about 0.5, whereas for waiting-list controls and active treatments the effect sizes are around 0.2 and 0.8, respectively. As we shall see, psychoanalytic research findings are consistent with these results, suggesting that the efficacy of psychoanalysis is based on the combination of a "non-specific" supportive component and a more specifically psychoanalytic contribution based on interpretation, experiencing, and overcoming transference neurosis, and that this combination results in the changes gained at the end of treatment being maintained, or

even improving further with time once treatment has ended – the so-called "sleeper effect".

Therapist and patient contributions to psychotherapy outcomes

The therapist–patient relationship appears to be a crucial factor in producing good outcomes (Cuijpers, Reijnders, & Huibers, 2019). This is a not unexpected finding and one that was anticipated by Freud (1940) in his notion of the therapeutic "pact", which he saw as the basis for successful analysis. Patients tend to attribute the success of treatment to the personal qualities of their therapists rather than to technical procedures. "Positive transference" features, such as seeing the therapist as warm, sensitive, honest, caring, understanding, supportive, and possessing a sense of humour, are associated with good outcomes. Conversely, where patients perceive their therapists as disliking, disrespecting, or finding it impossible to empathise with them, good outcomes are less likely. Lingiardi, Muzi, Tanzilli, and Carone (2018) found that symptom reduction in treatments with congruent/matching (i.e., complementary) patient–therapist relational processes was significantly better than with patient–therapist dyads who had conflicting characteristics. A complementary patient–therapist match was associated with larger effect sizes on all outcome measures, and with fewer patients not responding to treatment.

Therapists, of course, vary in their effectiveness, with some consistently achieving good outcomes, some being regularly ineffective, and most being somewhere in between (Okiishi et al., 2006). A further and intriguing finding in a longitudinal analysis of clinical outcomes not only found that the therapist is the greatest source of variance in outcomes but also reported (worryingly for senior practitioners!) that therapists' effectiveness tends to diminish as their experience increases (Goldberg et al., 2016). However, variability in outcomes is not simply a function of personal qualities and matching of patients with therapists and therapies; there is some evidence that therapists who adhere to a particular model of therapy, of whatever variety, are more successful than those who deviate too much from standard procedures. The relationship between therapists' fidelity to a model and outcome is complex, with some evidence that it plays only a limited role in determining the outcome; the findings are vitiated by the likelihood that therapists become increasingly adherent to their therapeutic model in an attempt to address a failing treatment (Webb, Derubeis, & Barber, 2010). Measuring adherence to psychoanalysis is also intrinsically difficult given the flexibility of implementation of core techniques, and the difficulty in specifying and operationalising them. Nevertheless, longer-term mentalisation-based treatment (MBT) for borderline personality disorder (BPD), described in more detail later in this chapter, has been shown to be three times less effective than optimal treatment when poorly implemented

(Bales et al., 2017). Such findings stress the potential impact on delivery of treatment programmes not only at the level of the therapist but also at the levels of the therapeutic team, the management, and the broader socio-cultural context in which treatment is delivered.

Characteristics of the patient and the therapeutic alliance contribute even more than therapists to outcomes in therapy. As mentioned earlier in this chapter, the more complex the problems of the patient, the worse the outcome, and there is ample evidence of the patient–therapist relationship being a determinant of outcomes in complex cases (Norcross, 2011) – in particular, there is evidence of the significance of the therapeutic alliance (Horvath, Del Re, Flückiger, & Symonds, 2011) and its recovery following ruptures (Safran, Muran, & Eubanks-Carter, 2011).

Given the importance of patient characteristics and the congruence of patient–therapist interactional reciprocity, attempts have been made to match the therapy to the patient. Introspective, "psychologically minded" patients may do better with non-directive, insight-oriented therapies such as psychoanalysis, while "externalising" patients do better with more directive approaches (Blatt, Zuroff, Hawley, & Auerbach, 2010).

Along the supportive–interpretive axis, it seems likely that patients with poor ego integration might do better with supportive approaches, while patients who show better integration and stable object-relational processes might respond well to a more psychodynamic type of therapy. An early cohort study, the Menninger Psychotherapy Research Project, explored this issue (Wallerstein, 1986). The study, which spanned a 25-year period, looked at assessment, treatment, and outcome in patients referred to the Menninger Clinic in Houston, USA, for psychoanalysis, 42 of whom were selected for intensive study. Treatments varied from full analysis to supportive psychotherapy. Most of the patients had severe psychopathology. The main findings of the study included the following:

1. 13 of 22 patients treated with psychoanalysis and 12 of 20 treated with psychotherapy did well, with good or moderately good outcomes.
2. Of the 22 patients who initially started with psychoanalysis, only six remained within the parameters of classical analysis; six had "modified classical" analysis, which included some supportive elements (e.g., the patient sitting up in sessions, the analyst wrapping blankets around a rain-drenched patient, telephoning suicidal patients at home, and admissions to hospital for patients in crisis); six were converted to supportive therapy, one of whom became a "therapeutic lifer", receiving 25 years of continuous therapy from four different therapists; and four were not identified in any category.
3. A "positive dependent transference" seemed to be the basis of all successful therapies, whether analytic or supportive.
4. Overall, there was only a weak relationship between "insight" and

change, although psychoanalysis was particularly associated with the presence of insight – whether this was because analysis led to insight or that insightful patients were selected for analysis was unclear.

5. An important aim of Wallerstein's study was to elucidate the controversy around the use of psychoanalytic techniques to treat severely disturbed patients. Kernberg (1975) suggested that a modified analytic approach, including the use of "psychodynamically guided hospitalisation", early interpretation of negative transference, and a focus on the here-and-now interactions rather than reconstructions, enabled severe borderline patients, and even some psychotic patients, to be treated successfully.

As discussed in Chapter 10, the conclusions about this group of patients, with whom psychodynamically minded psychiatrists will be all too familiar, were that the best form of therapy is "supportive–expressive" for however long it is necessary; that periods of hospitalisation will be required during long-term therapy; and that a network of informal support, often centred around the subculture associated with a psychiatric unit, is also an important ingredient if these patients are even to survive, let alone thrive.

Finally, it is worth reminding ourselves that "even if they had little chance with psychoanalysis, they might have had no chance at all with other forms of treatment" (Wallerstein, 1986, p. 681).

Immediate and long-term outcomes of psychoanalysis

Some analysts have, from the pioneering years, been aware of the need to study outcomes in psychoanalysis, even though there has been disagreement about the best way to do this and what should be measured. There are now a number of well-conducted studies that attempt to address questions about the effectiveness of psychoanalysis. As mentioned earlier, controlled studies of psychoanalysis, because of their prolonged nature, are difficult. Long-term psychodynamic psychotherapy offered more than twice a week is sometimes used as a proxy for psychoanalysis in research projects, as it is more available as a treatment and therefore easier to study. However, it does not have the intensity and frequency of psychoanalysis and may use some different techniques, and so can be considered to be a different treatment. Some research has reported on differences in outcomes between less frequent psychoanalytic psychotherapy and psychoanalysis. Early studies relied on analysts' assessments of the outcome of their patients. Independent observers were seldom used, and the records failed to use standard outcome measures, simply asking analysts to classify the results of treatment as "good", "poor", "mixed", and so on – an approach that has been criticised, as it may tempt analysts to overestimate the benefit of their treatments. Interestingly, the reverse seems to be the case, with observers rating

psychoanalysts as doing better than the analysts themselves think they are doing (Harty & Horwitz, 1976; Leichsenring & Leibing, 2003).

The distinction between symptomatic improvement and dynamic change is also one that has, at least until recently, bedevilled psychoanalytic outcome research, since the kinds of improvements that psychoanalysis hopes to produce are difficult to quantify easily. Many studies asked naturalistic, open questions of analysts about issues such as the development of an "analytic process" without specifying in a reliable way what was meant by this term. Measurements of personality change may be more meaningful and can be done by the use of self-report scales such as the Inventory of Interpersonal Problems (Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988), the Sense of Coherence Scale (Eriksson & Mittelmark, 2017), and the Social Adjustment Scale (Weissman & Bothwell, 1976). Combined with other psychoanalytically more relevant personality measurements, such as the Adult Attachment Interview (AAI) (George, Kaplan, & Main, 1985), the Minnesota Multiphasic Personality Inventory (Graham, 1993), and assessment of the quality of the patient's object relations (Kantrowitz, Katz, Paolitto, Sashin, & Solomon, 1987; Loeffler-Stastka & Blueml, 2010) and defence styles (Vaillant, Bond, & Vaillant, 1986), it is possible to look at outcomes that are meaningful to psychoanalysts and to the aims of psychoanalytic treatment over the long term, which include structural change of the personality. The Stockholm Outcome of Psychoanalysis and Psychotherapy Project (Sandell et al., 2000) was designed to address many of the faults of earlier cohort outcome studies of psychoanalysis by including a well-defined comparison group along with waiting-list controls. The study sample consisted of a group of 756 people in the Stockholm area of Sweden, who were offered subsidised treatment in psychoanalysis (three to five sessions per week) or psychotherapy (one to three sessions per week), or who were placed on the respective waiting list. The overall design was of a large cohort that was prospectively followed; patients were allocated according to assessments of need and suitability rather than being randomised, and were assessed using standardised instruments before, during, and after a maximum of 3 years of treatment.

Inevitably, the results of the study were complex. The largest effect of both treatments was on symptoms and there were limited effects on social adjustment, which is contrary to expectation in terms of psychoanalysis targeting change in internal object relationships rather than symptom reduction. The longer patients were in treatment the more they improved, so there was a dosage effect, which accounted for the differences between the two treatments in favour of psychoanalysis. The authors of the study suggest that some of the differences in outcomes may have been caused by many clinicians adopting "orthodox psychoanalytic attitudes" that may have been appropriate in psychoanalysis and so had no deleterious effect, but were counterproductive and possibly harmful in long-term psychotherapy. This

suggests that long-term psychodynamic psychotherapy is a different treatment that requires a range of skills that are distinct from those applied in psychoanalysis.

A study conducted in Helsinki, Finland, compared short-term psychodynamic therapy, time-limited solution-focused therapy, and long-term psychodynamic therapy for around 3 years for patients with anxiety and mood disorders, using a randomised controlled design (Knekt et al., 2008). Short-term psychodynamic psychotherapy was more effective than long-term psychodynamic psychotherapy during the first year. At the second year of follow-up, no significant differences were found between the short-term and long-term therapies, suggesting that the long-term treatment was slower to produce effects. It was only after 3 years that differences emerged between the short-term and long-term therapies. Long-term psychodynamic psychotherapy then became more effective in reducing general mental health symptoms, anxiety, and depression, thus giving credibility to the suggestion that longer-term treatment may be slower in action but has effects over the long term that are not achieved in shorter treatments.

Some patients in four- to five-times-weekly psychoanalysis were included in this study as a follow-along comparator, although they were not included in the initial randomisation. At 5-year follow-up, these patients were just completing their psychoanalysis. Their rate of improvement was slower than that of the patients in the short-term therapies, but at the 5-year point there was a stronger treatment effect for psychoanalysis for interviewer-rated symptoms of anxiety and depression. Importantly, in terms of indicators of structural change, there was greater improvement in work ability and functional capacity, and the effect sizes of measures of work ability were higher in psychoanalysis than long-term psychodynamic therapy (Knekt et al., 2011). The intensity and length of psychoanalysis perhaps facilitates a greater capacity for self-observation and self-analysis, which may account for this finding. This contrasts with findings from a study in the Netherlands comparing the outcomes of psychodynamic psychotherapy (once or twice per week) and psychoanalysis (three to five times per week). Over 2 years, only small differences were found, with the once- or twice-weekly treatment being marginally better in terms of reducing symptoms and improving interpersonal function (Berghout, Zevalkink, Katzko, & de Jong, 2012).

In meta-analyses, the superiority of longer-term psychoanalytic therapy over other shorter treatments is unclear. de Maat et al. (2013) concluded that there was evidence for pre–post changes, that is, changes between the beginning and the end of treatment, in psychoanalysis for patients with complex mental disorders, but that lack of comparisons with control treatments bedevilled the literature and was a serious limitation in interpreting the results.

Can meaning be quantified?

An important feature of any research method is its capacity to be used by all workers in the field, not just by those who devised it. Despite being cumbersome and expensive, the AAI (George et al., 1985), which is based on the principles of attachment theory (Bowlby, 1987; Holmes, 2013), is widely used in psychodynamic psychotherapy research. The AAI starts with interview transcripts but, unlike most instruments, it is concerned not so much with the content as the form and style of the patient's narrative. Like therapy itself, the AAI tries to "listen with the third ear" (Reik, 1922), but in a way that can be researched. A psychodynamic-type assessment interview is carried out, concentrating on the subject's past and present attachments and losses. It is assumed that subjects' underlying relational dispositions (which may well be unconscious) will be evident in the structure of their narrative and its consistency, freshness, coherence, elaboration, or restrictedness.

Interviews are assigned to one of three major categories: *secure-autonomous*, in which the interviewee talks openly and coherently about their childhood and parents, including painful experiences from the past; *dismissive*, in which narratives are not elaborated and interviewees have few childhood memories, tend to deny difficulty, and idealise or devalue relationships in a grandiose way; and *preoccupied*, in which the narrative style is muddled and confusing, and the interviewee appears to be dominated by affect from the past, such as anger or overwhelming sadness. In a fourth category, *unresolved/disorganised*, the AAI also identifies significant "breaks" or incoherence that may appear in any of the major categories and may reflect past trauma, such as sexual abuse, that has been repressed but momentarily surfaces during the interview.

The AAI can be used to study the relationship between assessment and outcome and to track change in psychoanalytic therapy, showing how individuals can move from dismissive or enmeshed to secure narrative styles as therapy progresses (Fonagy et al., 1995). In most studies, standard assessment procedures prove to be poor predictors of who will eventually do well in analysis, but the AAI indicates that, looking at the therapist's as well as the patient's attachment styles, the reciprocity of the patient–analyst "fit" may be important (Diamond, Stovall-McClough, Clarkin, & Levy, 2003).

The AAI has also been used to trace the intergenerational transmission of attachment patterns, showing how the classification of prospective parents on the AAI before their babies are born correlates well with the subsequent child's attachment status at 1 year of age (Fonagy, Steele, & Steele, 1991). An unexpected but important finding of this study was that infants appear to develop quite independent attachment patterns with each parent, so that they may be secure with the father and insecure with the mother or vice versa, depending on the parents' AAI. This is consistent with the psychoanalytic view of an inner or representational world containing models or

prototypes of relationships, which may act independently of one another. Presumably, similar internal models of attachment are built up in the course of therapy, which then supersede previous insecure relationship patterns.

One of the most widely known attempts to put psychoanalytic insights on a reliable, replicable, and scientifically reputable basis is Luborsky and colleagues' Core Conflictual Relationship Theme (CCRT) method (Luborsky & Crits-Christoph, 1989). Like the AAI, the method for the CCRT is laborious, but it yields psychodynamically meaningful data about the inner world. It starts from the idea that every therapy session contains a number of unconscious personal themes, which can be identified through studying transcripts of the sessions. Identifying the CCRT is a two-stage process. First, pairs of trained judges extract from the transcript a number of "relationship episodes" (REs) that have been described or enacted by the patient in the session – for example, a story about work or home, or the patient's reactions to the therapist. Most patients generate about four REs per session. The list of REs is then passed on to a second set of judges, who analyse them into three components: (a) the patient's wishes, needs, or intentions; (b) the response elicited from others, either positive or negative; and (c) the reactions of the self to the reactions of the others, again positive or negative. Common examples of wishes are for closeness, dominance, or autonomy; of responses are those of being rejected, controlled, or dominated; and of self-responses are anger, withdrawal, and disappointment. These categories are initially made freehand by the judges to produce "tailor-made" categories, which are then translated into a predetermined list of standard categories to allow more reliable comparisons to be made. From these standard categories there emerges a CCRT, or a set of CCRTs, which characterise the patient's core state. A typical example would be: the wish for closeness, feeling rejected, and responding with withdrawal.

By far the most reliable markers of change in psychotherapy are symptom ratings. These, however, are unsatisfying for psychodynamic researchers, who have tried to operationalise dynamic hypotheses. A significant early example was Malan's (1963) studies of brief therapy. An example involves a man with recurrent psychogenic blackouts, in which it was hypothesised that:

> He is afraid that he cannot cope with the responsibilities of masculinity. To take responsibility entails being aggressive and his fear is that this will result in (1) triumphing over his father and possibly (2) damaging the woman...he expresses his anxiety by losing consciousness... (Malan, 1963, p. 118)

However, it has proved impossible to achieve good inter-rater reliability by the Malan-type method in which raters attempt an overall formulation based on a case summary (DeWitt, Kaltreider, Weiss, & Horowitz, 1983).

CCRT formulations are much closer to experience and do not use sophisticated psychoanalytic concepts or terminology, but as they are highly reliable (Crits-Christoph, Cooper, & Luborsky, 1988) they have considerable flexibility as a research tool. They can be modified into a set of statements that the patient can then use to think about himself, a technique used in cognitive analytic therapy (Ryle, 1990): in the CCRT example mentioned above, the patient might agree to the statement "I want to be close but whenever I try to reach out and am rejected I withdraw, thereby perpetuating my isolation". CCRTs also correspond with the "core beliefs" found to be important in cognitive therapy.

Luborsky and colleagues have used CCRTs to research a number of important psychoanalytic issues (Luborsky & Crits-Christoph, 1998). CCRT "pervasiveness" decreases in the course of successful therapy, so that by the end of therapy patients are less dominated by their core themes – or, to put it differently, they become more psychologically flexible and open to new experience. Wishes change less than the responses they evoke, therapeutic change being associated particularly with the capacity to cope with negative responses and to elicit more positive ones from others, rather than some idealised "resolution" of underlying difficulties. An early study used CCRTs to look at the relationship between the "accuracy" of interpretations, as measured by their closeness to CCRTs (Crits-Christoph et al., 1988). In general, the more skilful the therapist, the better the outcome, especially insofar as they were able accurately to identify wishes and other responses. In both this study and a comparable one using the Plan Diagnosis Method (discussed later in this chapter; Weiss & Sampson, 1986), the accuracy of interpretation was related to good outcome, but the type of interpretation was not – that is, non-transference interpretations were just as effective as transference interpretations (Fretter, Bucci, Broitman, Silberschatz, & Curtis, 2010). Indeed, in another study, a high frequency of transference interpretations in brief dynamic therapy actually predicted negative outcomes (Piper, Azim, Joyce, & McCallum, 1991), perhaps, as mentioned earlier, because therapists focus more and more on transference in an attempt to retrieve a deteriorating therapeutic situation.

Luborsky et al. (Luborsky & Crits-Christoph, 1990; Luborsky, Popp, Luborsky, & Mark, 1994) believe that the CCRT approach provides the first scientific confirmation and objective measure of the concept of transference. By comparing the features of the CCRT with Freud's statements about transference, they confirm that (a) individuals have only a few basic transference patterns, (b) these patterns are manifest in their relationships, both generally and with the therapist, (c) transference patterns seem to derive from early parental relationship patterns, (d) transference patterns are as evident outside therapy as in it, and (e) these patterns are susceptible to gradual change in the course of treatment.

Transference interpretation as clinical technique

Alongside "external" aspects such as the use of the couch, supine patient, and frequency of sessions, for many psychoanalysts the focus on transference is what differentiates their work from other forms of therapy. Luborsky's research and most clinical case reports emphasise the central importance of interpreting transference in bringing about insight and positive change. Conflicts and themes identified in the therapeutic relationship through transference highlight the areas of difficulty in the patient's relationships outside therapy.

Detailed study of the role of transference in therapy, helpful and unhelpful, is an area of much psychoanalytic research. Any intervention may have side effects, and the interpretation of transference is no exception. There are reports that it can make patients too anxious, be overused when a therapy is already failing – making a bad situation worse (Ogrodniczuk & Piper, 1999; Ogrodniczuk, Piper, Joyce, & McCallum, 1999) – or be useful only to individuals who already have reasonably mature psychological capacities (Piper et al., 1991). However, it turns out that the situation is complex and multifaceted. Høglend et al. (2006) investigated the role of transference in brief psychoanalytic therapy by defining a transference interpretation in such a way that it could be reliably rated. They randomised 100 patients to treatment with or without transference intervention, monitoring interventions and looking at outcomes. At 1 year, both groups had improved to the same extent. However, patients who had a "poor quality of object relations", which had been assessed at the start of treatment, did better with the treatment that included transference interpretation in terms of their family and intimate relationships and friendships. This difference was maintained at 4-year follow-up. This important finding confounded expectations, as patients with low quality of object relationships were assessed as being *less* suitable for dynamic therapy. This is a good example of how empirical work can helpfully challenge and correct clinical and polemical myths.

Effectiveness of psychoanalysis

In a climate of concerns about the cost-effectiveness of treatments and the rise of brief treatments such as cognitive-behavioural therapy (CBT), psychoanalysis and psychoanalytic psychotherapy have been on the back foot for many years. However, the view that brief dynamic therapy is less effective than therapies like CBT has been challenged. Findings of equivalence have been reported in adults with depression, with a number of studies suggesting that psychodynamic therapy achieves similar outcomes to CBT in moderate to severe depression (Driessen et al., 2013; Steinert, Munder, Rabung, Hoyer, & Leichsenring, 2017). Overall, the outcomes of both

treatments in terms of changes in mood are disappointing, with only around 30% of patients responding to either treatment. Psychoanalytic therapy differs from CBT in specifically focusing on relationships and quality of life as well as symptoms, and so patients might be expected to show better results in terms of interpersonal relatedness when compared with those treated with CBT. In fact, somewhat disappointingly, both treatments tend to be equally effective on a range of measures looking at these additional outcomes (Connolly Gibbons et al., 2016; Driessen et al., 2017).

In a randomised controlled trial of depressed adults whose symptoms had been unresponsive to at least two active treatments, long-term twice-weekly psychoanalytic therapy for 18 months was added to TAU and compared with patients receiving TAU alone (Fonagy et al., 2015). Complete remission was rare in both groups, with only around 10% of patients in long-term psychoanalytic therapy achieving this ideal result. At the end of treatment, partial remission was no more likely in the group that received psychoanalytic therapy than in TAU. But when patients were followed up, those who had been in psychoanalytic therapy showed significantly more improvement than those given TAU at 24, 30, and 42 months, showing steeper declines in depression and greater improvements on measures of social adjustment. This again suggests that psychoanalytic therapy stimulates change over the long term, but this may become apparent only after treatment has ended.

Adaptations of psychoanalysis

As discussed in previous chapters, as early as 1938, Stern (1938) described a group of patients who responded in unusual ways to psychoanalytic intervention. This turned out to be a group whose symptoms later became known as BPD. Two variations of psychodynamic psychotherapy with roots in the psychoanalytic understanding of personality disorder have become evidence-based treatments for BPD: mentalisation-based treatment (MBT) and transference-focused psychotherapy (TFP). There are technical differences in clinical approach between TFP and MBT, although both rest on a bedrock of psychodynamic understanding. MBT uses more interpersonally directed and cognitive techniques focusing on preconscious process (i.e., thoughts and feelings that are accessible but of which the sufferer is unaware), while TFP uses transference to generate insight into unconscious process (where active repression and avoidance are postulated).

These technical differences may reflect differences in the setting and the clinical populations studied during the development of the two treatments. TFP, developed at Columbia University in New York, USA, is offered on a fee-for-service basis, covered at least in part by insurance companies. MBT, which was developed in London, UK, is offered in secondary care as part of a comprehensive health and social care service (the National Health

Service); it is free at the point of delivery and treats only the most severely affected patients. TFP is delivered by experienced psychoanalytic therapists, whereas MBT is commonly offered by nurses and social workers who are supervised by more experienced psychoanalytically trained practitioners. The differences between the two approaches may also be associated with differences in their theoretical origins. TFP represents a creative integration of drive theory and object relations theory. MBT is also an integration, but more specifically an integration of cognitive and psychoanalytic developmental theory and attachment theory. Despite these differences, research into both treatments illustrates many of the positive scientific features discussed earlier in this chapter: defining a treatment carefully, looking at effectiveness according to strict scientific criteria, and studying the relationship between process and outcome.

Mentalisation-based treatment

MBT is a structured treatment of 12–18 months combining individual and group therapy (Bateman & Fonagy, 2016). The aim of treatment is to increase the resilience of individuals' mentalising capacities (see Chapter 10) rather than to instil insight or make the unconscious conscious. The core of MBT is to rekindle mentalising when it is lost, to help the individual maintain it when it is present, and to increase the resilience of the person's capacity to sustain mentalising when faced with stress. A wide range of psychotherapy processes facilitate mentalising. Thus, MBT is pluralistic, using both psychoanalytic and cognitive interventions to further these aims. It was developed initially for the treatment of people with BPD because of their vulnerability to losing mentalising in relationships, but (as outlined later in this section), it is now being used to treat patients with a variety of other disorders.

In an initial study, Bateman and Fonagy (1999) compared the effectiveness of MBT in the context of a partial hospitalisation programme with that of routine general psychiatric care for patients with BPD. Results showed that the treatment group showed a statistically significant decrease on all measures of symptoms, while the control group showed limited change or deterioration over the same period. Improvement in depressive symptoms, decreases in suicidal and self-injurious acts, reduced numbers of inpatient days, and better social and interpersonal functioning began to be apparent in the MBT group after 6 months and continued to the end of treatment at 18 months.

A partial replication of this original trial has shown that good results are achievable in mental health services that are separate from the developers of the treatment (Bales et al., 2012, 2015, 2017). Further support comes from a study by Petersen et al. (2010), who treated 22 patients with personality disorders with once-weekly mentalisation-oriented group therapy for up to

3 years following a stabilisation phase in a day treatment programme. There were no dropouts from treatment. Significant improvements were observed in symptoms, interpersonal functioning, social adjustment, and vocational status, as well as an overall reduction in the use of services.

Post-treatment follow-up of patients treated with MBT shows that improvements are maintained over time, suggesting that this therapy stimulates longer-term rehabilitative changes. Follow-up at 8 years (Bateman & Fonagy, 2008) showed that patients treated with MBT remained better than those receiving TAU, although their general social function continued to be somewhat impaired. Significantly more patients who had been treated with MBT were in employment or full-time education than among the comparison group, and only 14% still met diagnostic criteria for BPD, compared with 87% of those in the comparison group who were available for interview.

An outpatient version of MBT was developed and was studied in another randomised controlled trial (Bateman & Fonagy, 2009). This study tested the effectiveness of an 18-month programme of MBT in an outpatient context against a structured clinical management approach to BPD (Bales & Bateman, 2012). Substantial improvements were observed in both treatment groups across all outcome variables, but patients randomised to MBT showed better outcomes, with a significantly steeper decline of both self-reported and clinically significant problems, including suicide attempts and hospitalisation. Improvements in both groups were maintained over 8 years of follow-up, but patients in MBT continued to show positive differences when compared with the control group (Bateman, Constantinou, Fonagy, & Holzer, 2021).

Group MBT (MBT-G) may be a useful way of providing MBT in busy clinical services (Karterud, 2015). Studying a predominantly group-oriented programme for adults with BPD, Kvarstein et al. (2015, 2017) compared the outcomes for BPD patients before and after an MBT programme was implemented. The patient group in the former psychodynamic treatment programme had baseline severity and impairments of functioning comparable to the group that received MBT. BPD patients receiving MBT-G showed a very low dropout rate (2%), which was significantly lower than the former treatment, indicating, according to the authors, that the MBT adaptations managed patients' excess anxiety and prevented flight/fight responses.

MBT-G has also been compared with psychodynamic group therapy (PDGT) in a randomised process–outcome study with 211 participants (Brand, Hecke, Rietz, & Schultz-Venrath, 2016). The results on a range of outcomes in patients with mixed anxiety and mood disorders suggest that MBT-G in a heterogeneous population in a day clinic is not superior to PDGT, but increases mentalising of the self to a greater extent than PDGT does. A further process–outcome study from the same authors, comparing the group relationships in PDGT and MBT-G after each session, showed

interesting differences between the treatments. There were higher conflict scores at the beginning of the group in MBT-G, while in PDGT there was more emotional avoidance during the course of therapy. The group conflicts of the patients who benefited the most from PDGT showed strong and ongoing fluctuations during the therapy process, whereas among those benefiting more from MBT-G, the fluctuations of the conflicts in group relationships were much shorter (Hecke, Brand, Rietz, & Schultz-Venrath, 2016). These results suggest that MBT, with its focus on the here-and-now and developing alternative strategies for managing conflict (both interpersonal and intrapsychic), may be especially helpful when treating patients with severe personality disorder, in whom unresolved conflict tends to lead to dropout from treatment.

Further research on mentalising and MBT has provided evidence that mentalising failures can be a useful target for treatment in adolescents with behavioural and affective problems. In one study of adolescents in an in-patient setting, a reduction in hypermentalising (but not other forms of mentalising) from admission to discharge appeared to be associated with a reduction in borderline symptoms over the same period (Sharp et al., 2013). Hypermentalising is a tendency to over-attribute motives to oneself and others, with limited grounding in reality. A fantasy explanation of oneself in relation to others is generated and there is "over-thinking" with excessive recruitment of cognitive processing. Reducing hypermentalising and increasing other aspects of mentalising allows the integration of affective experience with cognitive processing and a more accurate appraisal of reality. The presence of hypermentalising can also distinguish between adolescents with borderline personality pathology and other psychiatric disorders, and healthy control adolescents, on the basis of self-report (Sharp, Elhai, & Kalpakci, 2018). Finally, mentalising of the self (as operationalised through measures of experiential avoidance) was found to predict an increase in borderline symptomatology over the course of a 1-year follow-up period in 881 adolescents recruited from the community (Sharp, Kalpakci, Mellick, Venta, & Temple, 2015). That hypermentalising can be reduced through a mentalisation-based milieu approach to treatment (Sharp & Vanwoerden, 2015) accords well with the results of a recent study in Denmark, which showed a reduction in borderline symptoms in adolescents taking part in MBT-G (Bo et al., 2017).

The effectiveness of an MBT approach developed to treat adolescents who self-harm (MBT-A) was evidenced in a randomised clinical trial conducted by Rossouw and Fonagy (2012). MBT-A was organised as an individual and family intervention targeting the adolescents' mentalising ability, with a special focus on peer and family relationships and educational stressors. Results indicated that MBT-A was more effective than TAU in reducing self-harm and depression. MBT-A was associated with improved mentalising, reduced attachment avoidance, and improvements in emergent BPD

symptoms and traits. Programmes of MBT-A delivered as a peer-group intervention are currently being investigated.

A family-based mentalising intervention has been developed for families living with or supporting a family member/significant other with BPD. In a delayed-treatment randomised controlled trial, 56 family members were randomised either to immediate Families and Carers Training Support (MBT-FACTS), a supportive and skills-based programme consisting of five 1.5- to 2-hour evening meetings, delivered by trained family members selected on the basis of their enthusiasm and commitment, or to the same intervention but delayed by several months (Bateman & Fonagy, 2019). Family members randomised to the immediate intervention showed a significant reduction in reported adverse incidents between themselves and the identified patient in the second phase of treatment compared with those assigned to delayed intervention, and there were greater improvements in family functioning and well-being in the immediate-treatment group; these changes were maintained at follow-up. Again, the immediacy and conflict-resolving properties of MBT are highlighted in this result.

Finally, randomised trials suggest that MBT may be useful in treating a range of other disorders. Studies have reported on its use in the treatment of people with antisocial personality disorder (ASPD), in which aggression and violence are often prominent features (Bateman, Bolton, & Fonagy, 2013; Bateman, O'Connell, Lorenzini, Gardner, & Fonagy, 2016), substance use disorder (Philips, Wennberg, Konradsson, & Franck, 2018), and eating disorders (Robinson et al., 2016). Individuals with BPD and comorbid ASPD are more likely to show improvements in symptoms related to aggression when receiving standard outpatient MBT than those offered a structured protocol of similar intensity but excluding MBT components (Bateman et al., 2016). This study suggests that MBT may be a potential treatment for ASPD, particularly in terms of its relatively high level of acceptability and promising treatment effects.

Transference-focused psychotherapy

TFP is a psychoanalytic approach with a coherent theoretical frame of reference as well as a well-manualised set of technical procedures that includes measures of adherence (Clarkin, Kernberg, & Yeomans, 1999; Kernberg, Clarkin, & Yeomans, 2002; Kernberg, Yeomans, Clarkin, & Levy, 2008). It is rooted in Kernberg's (1967) theory of borderline personality organisation (BPO) (see Chapter 10). BPO is characterised by (a) identity diffusion, (b) primitive defences, (c) generally intact but variable reality testing, and (d) characteristic object relations.

Identity diffusion, a term that originates in the work of Erikson (1959), characterises the disparate, disconnected (split) self-representations that fail to cohere into an organised concept of the self. Thus, identity diffusion is a

reflection of a failure of developmentally expectable integration of aspects of the self. Primitive defences (splitting, idealisation/devaluation, and projective identification) are residues of early developmental phases and Klein's (1946) paranoid–schizoid position (see Chapters 3 and 4). BPO shares with psychotic personality organisation (PPO) primitive defences and identity diffusion. But, unlike individuals with PPO, those with BPO are able to differentiate self from non-self and internal from external reality, and have empathy with social criteria of reality. It should be noted that the distinction between BPO and PPO may not be as clear-cut as originally suggested by Kernberg. Psychotic symptoms have been increasingly commonly noted in individuals with a diagnosis of BPD (Gunderson, 1984).

TFP has been studied in a number of randomised controlled trials, which again illustrates how a treatment derived from psychoanalysis can be operationalised and subjected to empirical scrutiny. TFP was compared with dialectical behaviour therapy (DBT) (Linehan, 1993) and psychodynamic supportive therapy (Clarkin, Levy, Lenzenweger, & Kernberg, 2007). All three groups showed significant positive change on most measures, with TFP and DBT being associated with greater reductions in suicidality. Individuals receiving TFP showed improvements in their reflective function and their attachment style, suggesting that a focus on mental states and relationships had additional benefits (Levy et al., 2006). In a trial of 3 years of treatment for patients with BPD, comparing TFP with schema-focused therapy, patients in TFP showed much higher rates of dropout over time and smaller treatment effects on most measures (Giesen-Bloo et al., 2006). However, a further trial suggested that dropout could be reduced substantially: TFP was compared with treatment from community psychotherapists and the dropout rate was significantly less in TFP than in the comparison group. In addition, the reduction in suicide attempts during the treatment year was much greater in the group treated with TFP (Doering et al., 2010).

Single-case studies

Research that is remote from therapeutic reality is likely to be deemed irrelevant by practising clinicians. Since psychoanalysis is concerned primarily with single cases, there is an increasing literature using single-case, or "$N = 1$", design. Given how frequently single-case reports appear in the psychoanalytic literature (including, it must be said, in this book), it has been suggested that they could be systematically evaluated via a meta-analysis, on the basis that a single observation reported from one case but observed many times over different cases creates a database on which clinical theory can be developed (Meganck, Inslegers, Krivzov, & Notaerts, 2017). Systematic study of psychoanalytic process has also been made possible by the use of computer analysis of the vast amount of data generated by a single analytic treatment.

One example of this approach is the Ulm Psychoanalytic Process Research Study Group (Kächele, Schachter, & Thomä, 2008), in which computer analysis of frequently occurring key themes in ongoing psychoanalytic therapy suggests that therapy is always "focal", with a gradually shifting focus as therapy progresses. Through this increasingly organised and detailed work the single-case study has matured into becoming a research method that meets scientific credibility. Case studies are based on recordings of treatment rather than clinician report, information is gathered systematically throughout a treatment, clinical interventions are categorised, and computer-assisted analysis of dialogue before and after interventions and over time is used to understand the process of change.

The Mount Zion Psychotherapy Research Project (Weiss & Sampson, 1986) is another outstanding example of how important and scientifically reputable research can derive from the study of a particular case. In this project, a patient, "Mrs C", underwent a 6-year analysis, every hour of which was audio-recorded and transcribed. Her main problems were poor sexual adjustment and chronically low self-esteem. The eventual outcome was very good.

Weiss and Sampson tackled the material with the help of their operational formulation of psychoanalytic ideas, the Plan Diagnosis Method. They assume that patients carry with them a set of pathogenic beliefs about relationships, and, through the "Plan", with which they unconsciously test their therapists, hope that they will be disconfirmed. For instance, they saw Mrs C as suffering from "success guilt", which prevented her from enjoying her marriage or allowing herself to have sexual pleasure. They linked this to her relationship with her disabled younger sister, on whom a huge amount of parental attention had been lavished and with whom, therefore, Mrs C felt it was unsafe to compete successfully. Her consequent aggression about this neglect was transferred on to her husband.

Weiss and Sampson see the Plan as a cognitive–affective structure to which unconscious feelings and intellectual functions both contribute. Interpretations that are compatible with the Plan are assumed to be beneficial. The treatment of Mrs C went through several phases – initial attachment, resistance in the second and third years, a much freer but eroticised relationship to the therapist in the fourth and fifth years, and eventual termination with ambivalence and gratitude. Using the Plan Diagnosis Method, they tried to communicate with the unconscious impact of interpretations, finding, for example, that there was an increase in the "experiencing scale" following interpretations, which corresponded to the overall Plan as determined by independent raters.

In another single-case study, Moran and Fonagy (1987) followed the progress of a highly successful analysis of a 13-year-old girl with diabetes, using blood sugar readings as a marker of the state of her internal world and relating these to the analyst's detailed session recordings. Using the

statistical technique of "lag correlation", they showed that there was a temporal relationship between the interpretation of oedipal conflicts and the emergence of better diabetic control. They argue that findings such as these help to counter Grünbaum's (1984) claim that psychoanalysis is based on "suggestion", because the analyst was ignorant of, and made no reference to, the state of the patient's diabetic control.

Conclusion

The relationship between psychoanalytic practitioners and researchers has not always been easy. At worst, research merely demonstrates the irrelevant or the obvious, while clinicians ignore these findings or adopt an actively Luddite attitude towards them. Present-day research methods have become increasingly applicable to psychoanalytic practice as theoretical positions become less rigid and modern computer and video technology enables much more subtle probing of clinical reality. Clinicians, especially if publicly funded, increasingly recognise the need for scientific evaluation of the overall efficacy of their therapy, the robustness of their concepts, the impact of their interventions, and the nature of analyst–patient interactions. Freud's insistence that psychoanalysis be accepted as a science and be subjected to scientific study has moved from a pious hope to a reality.

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Chapter 12

The future of psychoanalysis: challenges and opportunities

Psychoanalytic perspectives on psychopathology have always emphasised both the adaptability of the human mind – symptoms have to be understood as compromises and trade-offs, the best sufferers have been able to come up with – and its tenacity in continuing to cling to solutions that have outlived their usefulness. Yet, when confronted with the rapidly evolving socio-cultural reality of 21st-century life, such tenacity is arguably as characteristic of psychoanalysts as of their patients. There has been a tendency to cling tenaciously to traditional theories and practices as though they had been written on tablets of stone, without critical reflection on the circumstances in which they came about. Given that well over a century has passed since the birth of psychoanalysis, and that the world today looks very different from the world in which the early pioneers developed their theories and practices, it is incumbent on us to consider what adjustments we might need to make to ensure the discipline's sustainability.

The 2020 COVID-19 pandemic has forced psychoanalysts to reflect on and re-evaluate some of their long-held shibboleths. Analysts who would never previously have dreamed of offering remote treatment have found themselves doing so. Many patients have adjusted to – or even welcomed – this, and even analysts who strongly dislike this way of working grudgingly acknowledge that it is "better than nothing" (White, 2020). Others have found that working remotely, although not without its challenges, is not incompatible with an analytic process. Some have drawn on Green's (2005) concept of the "internal setting" to conceptualise this (Miermont-Schilton & Richard, 2020). This refers not to external factors such as the couch, chair position, or the physical room, but to the psychic representation of the analyst as a holding symbol, analogous to the infant's sense of a maternal presence – or, in psychopathology, non-presence.

In a separate but related development, the global social inequalities exposed by the pandemic and the Black Lives Matter movement have increased the sense within psychoanalytic communities that there is an urgent need to address their lack of diversity, as illustrated, for example, by the American Psychoanalytic Association's recent announcement of the Holmes Commission on Racial

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Equality with a mission to investigate systemic racism and its underlying determinants within the Association. There is increasing recognition within psychoanalytic organisations of their comparative failure to appeal to patients – and candidates – who do not fit into a narrow class and cultural demographic (typically White, heterosexual, and relatively affluent), and a dawning awareness of the unexamined prejudices that have mis-shaped psychoanalytic theory and practice. This has led to measures such as the introduction of seminars on ethnicity and culture in psychoanalysis in training curricula, although these are usually optional and offered relatively late in the course of a training.

Freud anticipated that the narrow scope of psychoanalysis would eventually need to be overcome. In 1919, in the aftermath of the First World War and the influenza pandemic that had claimed at least 50 million lives worldwide, he famously wrote:

> it is possible to foresee that at some time or other the conscience of society will awake and remind it that the poor man should have just as much right to assistance for his mind as he now has to the life-saving help offered by surgery; and that the neuroses threaten public health no less than tuberculosis, and can be left as little as the latter to the impotent care of individual members of the community…Such treatments will be free. It may be a long time before the State comes to see these duties as urgent. Present conditions may delay its arrival even longer. Probably these institutions will first be started by private charity. Some time or other, however, it must come to this. (Freud, 1919, p. 167)

Apart from its sadly still relevant call for parity between physical and psychological medicine (Lazar et al., 2018), this paper is famous for Freud's distinction between the "pure gold" of analysis and the "copper" of other methods. However, unlike many of his successors, Freud did not oppose the creation of alloys in the service of public health. Instead, he argued that

> whatever form this psychotherapy for the people may take, whatever the elements out of which it is compounded, its most effective and most important ingredients will assuredly remain those borrowed from strict and untendentious psycho-analysis. (Freud, 1919, p. 168)

For Freud, what defined psychoanalysis was not a specific set of practices but a clinically derived understanding of the dynamics of the human mind, which could potentially have a variety of clinical and non-clinical applications. In this final chapter, we will consider some of the current challenges facing the field and argue that a resilient response requires a degree of self-scrutiny and adaptation if practitioners, theorists, and advocates of psychoanalysis are to rise to the occasion. We begin with the vexed question of remote working using the telephone, Skype, Zoom, and other virtual

platforms. This is an issue that has been the subject of passionate debate since the turn of the century (Argentieri & Mehler, 2003; Bassen, 2007; Ehrlich, 2019; Merchant, 2016; Scharff, 2012; Turkle, Essig, & Russell, 2017), and circumstances at the time of writing have forced every working psychoanalyst to grapple with it. We then consider the troubled history of psychoanalytic thinking about psychosexual development and the challenges posed by the proliferation of sexual and gender identities in the 21st century. Finally, we discuss the equally troubled history of the discipline's difficulties with issues of race, ethnicity, and culture.

Teleanalysis

Traditionally, the psychoanalytic setting has included a conventionally dressed analyst who does not reveal too much about him/herself; a couch for the patient with a comfortable chair behind for the psychoanalyst; and sparsely furnished surroundings. The aim is to create a minimalist, somewhat ambiguous physical setting, insulated as far as possible from the impingements of external reality, to create conditions that facilitate focus on the patient's internal states of mind.

The psychoanalytic encounter itself creates a virtual reality: a life story, past and present, is co-created and filtered through free association, object-relational activation, and transference. Reaching for a metaphor that would capture the essence of psychoanalytic listening, Freud himself chose the telephone: "[The analyst] must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient. He must adjust himself to the patient as a telephone receiver is adjusted to the transmitting microphone" (Freud, 1912, p. 115). Psychoanalysts learn to feel at home with this virtual reality while, paradoxically, doing so with another living, breathing being in the same room, whose presence is considered necessary for the development of transference and the analyst's subjective counter-transference experience. Immediate interactional process and corporeality are central to the treatment process and are used to integrate subjective communication and the atmosphere of the session with more objective understanding of the content of the dialogue.

However, in this era of rapidly evolving technology and epidemic disease, this time-honoured, cosy model has been called into question. The forms and styles of social and personal relationships in general are changing, driven by the ubiquity of cyberspace, the internet, and other communication channels, just as they did a century earlier with the invention of the telephone. People have internet relationships, Skype sex, and intimate discussions that they might not necessarily be prepared to have in person. Many adolescents communicate more through text messages and social networking sites than they do in person. Others inhabit their own fantasy worlds in cyberspace. For some young people, computer games become more real

than the "real world", which is experienced as alien and uncomfortable. The conventional boundaries and channels of communication between the internal world and the external world are blurred and imponderable. The virtual worlds they inhabit feel safer and more manageable than what their elders describe as reality.

It is chastening to remember that psychoanalysis in the consulting room, too, can become a world in itself without links to "real" life, a retreat from rather than a bridge to a better life. It is all too easy for older generations to pathologise new ways of living, criticising them as escapes, defences against psychic pain, or narcissistic retreats, rather than seeing them as potentially new ways of relating. The analyst is in danger of becoming the dinosaur who is unable to recognise and adapt to the significant changes taking place in how people live. Conversely, failing to recognise the inherent pitfalls of the internet is equally dangerous, leaving young people alone with their problems – for example, a broadband "outage" may create unmanageable anxiety. Individuals with social anxiety, shyness, loneliness, or depression may spend significantly more time on the internet than their peers. This overexposure to the virtual world can sometimes lead to cyberbullying and exploitation. So, can contemporary internet-savvy psychoanalysis roll up its sleeves, join in the free-for-all of technology, and take advantage of all the new media? Is it ready to embrace – and indeed exploit – new forms of interaction and relationships for good ends, rather than seeing them as existential threats to the core values and practices of psychoanalysis, while commenting on them from an elevated distance?

Distance training of psychoanalysts is now available. Cross-border telephone psychoanalysis has been practised for many years, with reports that telephone sessions are indistinguishable from in-person sessions, and "shuttle analysis", which involves concentrated bursts of sessions interspersed with long gaps, has been considered acceptable (Cundy, 2014; Scharff, 2018). With advances in technology, many of these arrangements, originally devised to overcome practical problems, can move into the mainstream and can be done "in person" over the internet using VoIP (Voice over Internet Protocol, i.e., internet telephony) as part of the standard repertoire of psychoanalytic treatment and training. Web-based training analyses are the norm for clinicians in countries where psychoanalytic treatment is still in its infancy, for example, China (Scharff, 2019). People living in remote parts of a country can be offered analysis, and those with social and intimacy anxiety, perhaps due to past trauma, may be able to participate online when they would be unable to come to a consulting room. Social distancing measures implemented to control the worldwide coronavirus pandemic have forced almost all analyses to be conducted online. This new environmental context for psychoanalysis, and an increasing number of practitioners being trained in this way, will perhaps result in a better definition of, and research investigation into, the internet "method". We need to know more about its advantages and limitations – for example,

how it differs in terms of technique, and what problems it stimulates or reduces in contrast to face-to-face treatment.

Lemma and Caparrotta (2013) report that it was difficult to find an analyst who was willing to write about Skype analysis as a "method" even though a survey suggested that around 30% of members of the British Psychoanalytical Society had conducted at least one full telephone or Skype analysis. Analysts reported that they did some analysis using this medium but did not feel they had enough experience to write about it as most of their work was done in person. Nevertheless, recommendations include seeing the patient in person initially for the assessment, having a trial of sessions by telephone or VoIP, and holding in-person reviews at regular intervals.

Decisions need to be made about the patient seeing the analyst in his or her home situation at the start of the session, and then changing the structure so that free association is not compromised. Should the analyst turn off their video at this point, or are the sessions conducted face to face; are headphones used? Working with unconscious processes within a cyberspace reality presents its own problems. Internet-based interactions generate a different dynamic from in-person relationships. Non-verbal cues are muted or less subjectively experienced; the countertransference responses of the analyst or their emotional states may be based more on the technology than the person at the other end of the electronic communication channel. For example, the analyst might think a patient has fallen silent when in fact the audio on the computer has failed. Despite these drawbacks, the virtual space between the analyst and patient can become, as accustomed, a transitional space in which to play, unconstrained by actuality, or a shared reality much like the atmosphere of the consulting room. Transferences arise just as much over telephone and internet interactions as they do in person, albeit filtered and modified by the medium. It has been suggested that headphones and VoIP can bring the patient and analyst closer mentally and heighten their interactions (Scharff, 2012).

The ready availability of information on the internet has rendered the analyst's personal privacy somewhat obsolete (back in the 1970s, J.H.'s analyst stated that he was ready to own up to all information that was available in the current edition of *Who's Who*!). Even a cursory search on Google can bring up more information about an individual than the person themself remembers. One patient used internet searches for conferences and seminars to track her analyst when he cancelled a series of sessions outside normal break times. In sum, if psychological health implies flexibility and adaptability, it behoves psychoanalysis to move with the times and realign its practices in tune with the internet age.

Sexuality and gender

Freud's *Three Essays on the Theory of Sexuality* (Freud, 1905) were groundbreaking both in placing psychosexuality at the heart of psychic

development and in their critical analysis of the tendency to assume that people of a particular sex will (except in cases of pathology) seek someone of the opposite sex as their sexual object, with genital intercourse and procreation as their sexual aim. In a striking footnote to the *Three Essays*, added in 1915, Freud wrote that

> psycho-analysis considers that a choice of an object independently of its sex – freedom to range equally over male and female objects – as it is found in childhood, in primitive states of society and early periods of history, is the original basis from which, as a result of restriction in one direction or the other, both the normal and the inverted types develop. *Thus from the point of view of psycho-analysis the exclusive sexual interest felt by men for women is also a problem that needs elucidating and is not a self-evident fact.* (p. 143, our italics)

The "normal sexual aim" is similarly problematised, with Freud notably concluding from his study of the so-called perversions that

> No healthy person…can fail to make some addition that might be called perverse to the normal sexual aim; and the universality of this finding is in itself enough to show how inappropriate it is to use the word perversion as a term of reproach…the sexual instinct itself may be no simple thing, but put together from *components* which have come apart again in the perversions. (Freud, 1905, pp. 160–162, our italics)

Despite his theoretical and ethically tolerant perspective, it must be acknowledged that there is also a heteronormative tendency in Freud's writing, which became far more pronounced in the work of many of his successors. The third of the *Three Essays* defines the "final, normal shape" (Freud, 1905, p. 207) of mature sexual life in terms of heterosexual object choice. As the socio-political context changed in the 1930s and analysts began to seek to establish their practices in new locations, Freud's subversive suggestion that heterosexuality, just as much as homosexuality, could be understood as a more or less precarious coming to terms with the polymorphous nature of infantile sexuality was drowned out by voices asserting a biological underpinning for prevailing social norms.

For example, writing from the United States, the Hungarian analyst Sandor Rado (1940) asserted that "It is imperative to supplant the deceptive concept of bisexuality with a psychological theory based on firmer biological foundations". Homosexuality came to be seen more and more as a deviation from "normal" sexual function rather than a variation thereof, perhaps to mitigate the risk of psychoanalysis being perceived as threatening to the social order in its newfound home (Herzog, 2015). Homosexuality was often conceptualised in terms of anxiety about heterosexuality (Rado, 1940, 1969)

and/or a wilful blindness to sexual difference and refusal to recognise the "facts of life" as defined by Money-Kyrle (1971), who believed that we are born with innate pre-conceptions of the breast as a supremely good object and parental intercourse as a supremely creative act.

Notwithstanding Freud's view that there was as little prospect of "converting" homosexuals to heterosexuality as the reverse, this kind of thinking led to misguided attempts to "cure" homosexual patients (Bieber et al., 1962) and assertions of the desirability of such efforts, causing unnecessary pain and damage directly to the patients themselves (Isay, 1996; King, 2011; Roughton, 2002) and indirectly by contributing to the legitimisation of homophobic attitudes in wider society (Bergler, 1956).

The pathologisation of homosexuality has cast a long shadow over psychoanalysis. In both the United Kingdom and the United States, its categorisation as a "perversion" led to the exclusion of openly gay men and lesbians from psychoanalytic trainings. Psychoanalytic clinicians were woefully ignorant of, and often prejudicial about, the realities of the LGBT community (Newbigin, 2013). An official move towards non-discrimination was made by the American Psychoanalytic Association in 1991, but this was not followed by the International Psychoanalytical Association until 2002. In the United Kingdom, as recently as 1995 the Association for Psychoanalytic Psychotherapy in the NHS invited the American psychoanalyst Charles Socarides, who was well known for his view that homosexuality was a pathological condition in need of cure, to give its annual lecture. This provoked significant protest, but, although a lively debate ensued, within the organisations under the umbrella of the British Psychoanalytic Council (BPC) an "uneasy silence" prevailed (Clarke & Lemma, 2011). A survey of members of the BPC conducted at the start of the current century indicated that a significant number of respondents still believed that LGB sexual orientation could be favourably changed to heterosexuality (Bartlett, King, & Phillips, 2001). It was not until 2012 that the BPC agreed a position statement on homosexuality, which began: "The BPC does not accept that a homosexual orientation is evidence of disturbance of the mind or in development" (Newbigin, 2013). The American Psychoanalytic Association formally apologised for its role in perpetuating the misunderstanding of homosexuality as an illness in June 2019, on the 50th anniversary of the Stonewall riots (a series of spontaneous demonstrations by members of the gay community in June 1969 in response to a police raid on the Stonewall Inn in New York, widely considered to have been one of the key events leading to the emergence of the gay liberation movement in the United States).

What is the relevance of this foray into psychoanalytic politics for everyday practice? In Freud's original formulation, the counterpart for the analyst of the "fundamental rule" is evenly suspended attention (see Chapter 8):

> The rule for the doctor may be expressed: "He should withhold all conscious influences from his capacity to attend, and give himself over completely to his 'unconscious memory'. Or, to put it purely in terms of technique: "He should simply listen, and not bother about whether he is keeping anything in mind". (Freud, 1912, p. 112)

However, as Chodorow (1999, p. 99) has pointed out, the laudable aspiration to listen without prejudice is complicated by the fact that "We psychoanalysts embed conscious and preconscious, unthought and unnoticed, pretheoretical cultural assumptions about gender in our theories and thus shape what we see and hear clinically". This issue is much less visible when the cultural assumptions of both parties to the analytic encounter are shared. However, when analysts encounter patients whose sexual orientation is different from their own, or who come from a different culture, the risk of ignorance or prejudice on the analyst's part undermining the patient's trust increases significantly (Newbigin, 2013). The process could be construed as "cultural countertransference" (Foster, 1998).

It is instructive to bear in mind that although in contemporary Western society we often think of sexuality as defining an important aspect of "the truth about ourselves" (Foucault, 1976, 1984a, 1984b), "sexuality" as a term was introduced only at the end of the 19th century (Lemma & Lynch, 2015). Freud put it thus:

> In conformity with its peculiar nature, psycho-analysis does not try to describe what a woman is – that would be a task it could scarcely perform – but *sets about enquiring how she comes into being*, how a woman develops out of a child with a bisexual disposition. (Freud, 1933, p. 116, our italics)

Post-modern cultural theorists such as Judith Butler (1999) have drawn on psychoanalysis to develop the argument that identity is not given but culturally constructed. Ironically, contemporary psychoanalysts have often been reluctant to consider the ways in which their own psychoanalytic identities and theoretical constructs may have been shaped by broader social, political, and cultural forces. Historically, the focus on the analytic dyad (and, in some schools of thought, the hyper-focus on the mother–child dyad) has bracketed out consideration of the wider cultural contexts that inescapably permeate the analytic encounter. The analyst, however interpersonally ambiguous a stimulus he or she aims to embody, cannot – and, some would argue, should not – present a totally "blank screen". Skin colour, sexual mannerisms, tone of voice, vocabulary, dress code, hair style, the presence or absence of tattoos, jewellery, a wedding ring, the ambiance and arrangement of the furniture of their room – all speak to an inescapable socio-sexual-cultural context. Exploring these questions effectively with a

patient requires the analyst to adopt a mentalising stance in relation to their own assumptions as well as the patient's (Fonagy & Allison, 2015).

As analysts have belatedly and tentatively begun to consider the heteronormative assumptions that have impaired their ability to listen to some of their patients and barred lesbians and gay men from psychoanalytic training (Allen, 2010), the range of possible ways of describing one's gender and sexuality has been increasing; there are, it seems, now over 70 options available to users of Facebook (Lemma, 2018). Several decades of feminism and queer theory have undermined the possibility of sorting people neatly in terms of the binary oppositions of male and female, homosexual and heterosexual (Goldner, 2011), and in the early 1990s "transgender" began to emerge as an umbrella term for a very diverse range of gender-variant people and sexualities discrepant with the sex they were assigned at birth. Transgender should not be conflated with transsexual, since for some, identifying as transgender means existing in between the gender binary, or outside it altogether. "Trans is not one thing…In addition to 'transition' ('A to B') and 'transitional' ('between A and B'), trans can also mean 'A as well as B' or 'neither A nor B' – that's to say, 'transcending', as in 'above', or 'in a different realm from', both" (Rose, 2016). Thus, identifying as transgender does not necessarily entail altering one's body with hormones or surgery. However, in the United Kingdom, the number of referrals to the Tavistock and Portman NHS Trust, which provides the national gender identity service in the United Kingdom for under 18s, rose approximately ten-fold between 2010 and 2017 (Butler, de Graaf, Wren, & Carmichael, 2017). There has been heated debate about whether the cases referred to this service have been managed appropriately. On the one hand, there were concerns about whether young people referred to the service were being fast-tracked to receiving hormonal or surgical intervention without adequate psychological evaluation (Evans, 2020). On the other hand, anxiety about repeating the mistakes of the past with respect to homosexuality and falling into the trap of engaging in a form of "conversion therapy" has led to the promotion of a "gender-affirmative" approach (Hidalgo et al., 2013) and suspicion that efforts to slow down the transitioning process and allow time for reflection about its meaning to the young person are manifestations of "transphobia". The debate has become so polarised that little room is left for uncertainty (in the young person) or curiosity (in the parents, teachers, and professionals the young person encounters).

Jacqueline Rose has drawn attention to the possibility that the desire for transition may come as much from the parents or adults as from the child, citing the example of a headteacher who told a mother that her son needed to stop dressing ambiguously because he was being harassed at school. Rose comments: "Better transition over and done with, it seems, than adults having to acknowledge, remember, relive, the sexual uncertainty of who we all are" (Rose, 2016).

Drawing on her extensive clinical experience of working with young people who identify as "trans", Alessandra Lemma has argued that transgender individuals do not form a homogeneous group to whom a single theory can be applied, and that the decision to have surgery *per se* is not an indicator of pathology: the key issue is what states of mind underpin its pursuit (Lemma, 2018). She proposes that the difficulties experienced by people who identify as trans highlight what is in fact a universal challenge of coming to terms with the body we are born into ("we are born a body and we have to become one"; Lemma, 2018, p. 1100): our bodies have a quality of otherness and yet they are irreducibly our own, and when it comes to self-presentation almost everyone engages in some degree of body modification, whether it be hair styling and grooming, particular styles of dress that constrain the body in different ways, diet, exercise, cosmetics, tattoos, or cosmetic or bariatric surgery. The challenge of coming to terms with one's body becomes particularly acute in adolescence, a time when dramatic body changes occur at a rate that can feel alarming. Lemma advocates a stance of "equidistant curiosity" about the meaning of the desire to modify the body without presuming that it is either a sign of pathology or a sign of creativity, stressing the need for time and space for reflection. Both Lemma and Rose argue against the current tendency to shut down questioning about how a person has come to be the way they are on the grounds that such questioning is intrinsically pathologising, as articulated by Ken Corbett in relation to homosexuality:

> When it comes to the question of the origin of sexual identity, I am willing to live with not knowing. Indeed, I believe in not knowing…Through this assertion, I do not mean to imply that I do not set out with my patients to understand – to the degree that we can – in what manner or way their sexuality has developed. But my effort in this respect is guided by the question, "How homosexuality?" (with what meaning and to what effect) as opposed to what I consider to be the ill-conceived etiological project of "Why homosexuality?" (for what reason, cause, motive, or purpose). (Corbett, 1997, p. 500)

An important safeguard may be the analyst's ability to accept that they cannot know in advance of a mutually respectful exchange with the patient how that person has come to assume the identity they bring, and to consider the possibility that their own identifications (e.g., as cisgender, i.e., having a gender identity in line with one's birth sex, and heterosexual) may complicate their perceptions of the patient. Working with patients who identify as trans requires psychoanalysts not only to hold their preconceptions, assumptions, and prejudices in suspension but also to re-examine them in light of what they hear.

It is of course possible to argue that this attitude has been fundamental to the analytic stance since the beginning. Indeed, Freud's ability to set aside his assumptions defined its emergence in his work with his hysterical patients, for example, in the case of "Frau Emmy von N" (Breuer & Freud, 1893–1895), who at some point under cross-examination by the eager young doctor irritably told him to stop asking her questions and let her *tell him* what she had to say. (To his credit, he did as he was told.) Yet, although we might like to think that we adopt this stance, the reality is often different. In a late paper titled *Emotional Turbulence*, Bion observed that "Whether anybody wants to hear what they might hear thanks to increased powers of understanding, is an open question" (Bion, 1976, p. 122). Adopting the Bionic stance – more honoured in the breach than the observance – returns us to feelings of ignorance that we tend to pride ourselves on having overcome. Bion's poignant point is that analysts, being as human as their patients, will inevitably share this reluctance to reopen seemingly resolved questions in the face of new data, and that this reluctance can and should be recognised and resisted.

Race and culture

Another issue that has exposed some of the limitations of psychoanalytic understanding is the profession's collective denial of the importance of issues of race and culture. To understand the origins of this denial, we have to consider the socio-cultural context in which psychoanalysis emerged. As a Jew in the antisemitic culture that existed in early 20th-century Vienna, Freud experienced economic hardships, prejudice, and barriers to professional advancement that led him to believe that to safeguard the future of his new science of the mind he needed to find ways of ensuring that it would not be perceived as essentially Jewish. He told one of his analysands, Abraham Kardiner, that he hated the idea that "psychoanalysis would founder because it would go down in history as a 'Jewish' science" (Kardiner, 1977, p. 70). A significant reason for his initial championing of Jung as his successor was his belief that placing him at the head of the psychoanalytic movement would counteract the tendency for psychoanalysis to be seen in this way (Gilman, 1992). To another analysand, Smiley Blanton, he acknowledged that

> "My background as a Jew helped me to stand being criticized, being isolated, working alone…All this was of help to me in discovering analysis" but went on to say, "But that psychoanalysis itself is a Jewish product seems to me nonsense. As a scientific work, it is neither Jewish nor Catholic nor Gentile". (Blanton, 1971, p. 43)

In order to claim for psychoanalysis a place among the natural sciences, Freud was committed to the position that an appreciation of ethnic and

cultural differences was not essential to understanding the workings of the human mind, whose functioning could be understood scientifically no less than human anatomy and physiology. In a birthday address to Ernest Jones in 1929, he maintained that ignoring ethnic and cultural differences is appropriate:

> The first piece of work that it fell to psycho-analysis to perform was the discovery of the instincts that are common to all men living to-day – and not only to those living to-day but to those of ancient and of prehistoric times. It called for no great effort, therefore, for psycho-analysis to ignore the differences that arise among the inhabitants of the earth owing to the multiplicity of races, languages and countries. From the start it was *international*, and it is well known that its followers overcame the dividing effects of the Great War sooner than any others. (Freud, 1929, p. 249)

Ironically, we can see that Freud's claim for the universal and cross-cultural applicability of psychoanalysis was at least partially shaped by the historically and culturally specific context out of which that theory emerged. Ironically, too, the tendency to deny that a person's race and culture has any relevance has profoundly restricted the capacity of psychoanalysis to address the concerns of those who are not White and middle class, as evidenced by the concerningly low numbers of Black and minority ethnic (BAME) people entering the profession on both sides of the Atlantic (Morgan, 2008; Stoute, 2017), and the low numbers of BAME people in treatment. A 2004 interview study (James-Franklin, 2004) of Black psychoanalytic psychotherapists who had trained in a number of different organisations in the United Kingdom found that

> Generally the climate was one of colour-blindness where trainers, supervisors and analysts took the position that differences in colour are not relevant as we are all the same. This meant a failure to acknowledge any matter of difference and required the black trainee to ignore important aspects of her or his experience. (Morgan, 2008, p. 35)

The implicit or explicit communication to Black trainees and patients that differences in colour are irrelevant or insignificant has far-reaching implications. Frank Lowe commented that "I haven't met a black therapist or trainee therapist who has been satisfied with their training organization's handling of race issues or feels confident that the profession is addressing the problem" (Lowe, 2006, p. 56). Marginalisation may be literal as well as metaphorical. Working in a "periphery of excellence" in the west of the United Kingdom, a further implication of institutional colour-blindness and

deafness is highlighted in Farhad Dalal's observation that "the point about being at the margins is that the centre finds it hard to hear, partly because of psychological distance, and partly because what is being said is inconvenient. And so the marginalized are forced to shout until hoarse and can end up sounding shrill" (Dalal, 1998, pp. 206–207).

Another way in which ethnic and colour differences become situated as peripheral to the true concerns of psychoanalysis is by treating patients' attempts to discuss their significance as the equivalent of the manifest content of a dream, that is, insignificant in themselves except insofar as they provide access to deeper layers of the mind. A famous example of this occurred in the course of Ralph Greenson's treatment of Ellis Toney, the first African American candidate admitted to the Los Angeles Psychoanalytic Society and Institute. Toney requested a change in the time of his analytic session because, being the only African American on the street in Greenson's neighbourhood at the original time, he was sometimes stopped by the police (Hamer, 2002). Greenson interpreted this as a manifestation of paranoia. Forrest Hamer has written that "Experiences of race in analysis are often conceptualized as resistances, as guards at the gate that stand in the way of analyzing unconscious thoughts and fantasies" (Hamer, 2002, pp. 1220–1221), and reminds us that while racial material can be used to avoid awareness of other material, it is also true that all kinds of other material can be used to avoid the meaningful consideration of race.

All of this is a problem, but, as Morgan (2008) asks, *for whom*? There has been a tendency to see the lack of BAME analysts and therapists, and the low numbers of BAME patients in psychoanalysis and psychotherapy, as a problem for Black people. Various reasons – no doubt valid – are advanced for this lack of representation: socio-economic inequalities, lack of available role models, stigma about mental health issues and accessing help for them in Black communities, suspicion of White professionals perceived as unlikely to understand some of the issues facing Black people, and so on. If the problem is understood in this way, it follows that attempted solutions should focus on strategies such as more effective and targeted outreach and recruitment, scholarships and bursaries, diversity training, and the like. These kinds of approaches certainly have a place. However, Morgan argues that if the issue is understood as a problem for Black people this means that the White majority do not experience *themselves* as having a problem that needs to be addressed, and not merely out of a sense of social conscience. If institutional and personal racism is simply denied – as it sometimes is – this negates any sense of responsibility for the situation. Seeing the difficulty as Black people's problem leads to a lack of awareness that the institutions, theories, and practices of psychoanalysis are impoverished by failing to engage with the issues brought into focus by psychoanalytic work with patients whose ethnicity differs from that of the analyst. This in turn avoids

the issue that racism, however implicit, is a problem for *everyone* in the psychoanalytic community, not just for the BAME people on the margins.

What would a meaningful consideration of race involve? First, it involves recognising that personal identity is shaped by the wider cultures in which we are embedded, and that these have effects on both the nature of family relations and the ways we experience our bodies. The complex interplay of social and psychic reality comes into sharper focus when the two parties in the analytic encounter cannot take a shared culture for granted. However, such encounters highlight that what transpires in the consulting room cannot be conceptualised as taking place on international or neutral ground, in a psychic reality that lies beyond "the differences that arise among the inhabitants of the earth" (Freud, 1929, p. 249). As we saw, historically psychoanalysis sought to lay claim to scientific authority by denying the significance of social realities and, like any denial, this needs to be addressed and worked through.

Second, the categorisation of people into races, and the racism intrinsic to that gesture (Kovel, 1988), involves aggression and destructiveness that – like everyone – we struggle to face in ourselves. Freud wrote in *Civilization and its Discontents* that "It is always possible to bind together a considerable number of people in love so long as there are other people left over to receive the manifestations of their aggressiveness" (Freud, 1930, p. 114), and, as Dorothy Evans Holmes has stated, "The fact of racial difference is probably as powerful a trigger and container for the projection of unacceptable impulses – with resulting prejudices toward the object of projection – as we have in our culture" (Holmes, 1992, p. 2). In a similar vein, Michael Rustin has written that "'Race' is both an empty category and one of the most destructive and powerful forms of social categorization" (Rustin, 1991, p. 57). Part of the difficulty of analyses where the members of the dyad do not share the same ethnicity is that it becomes much harder to avoid confronting this aggression and destructiveness, and awareness of it can arouse such shame in the analyst that it becomes impossible to speak of, to the patient or even to him/herself.

In a 1992 paper titled "Enclaves and Excursions", Edna O'Shaughnessy described two ways in which she thought that the analytic encounter could go awry: one when the analyst becomes the object that the patient requires to such a degree that the analysis turns into a refuge or enclave, and the other when the patient is so frightened of the emotional situation created by the analysis that they are in constant flight into discussions of anything and everything else (O'Shaughnessy, 1992). O'Shaughnessy notes that these tendencies are often associated respectively with an excess of transference and extra-transference interpretations, but she comments:

> When we discuss different ways of talking to our patients, I think it more useful, rather than asking whether an interpretation is a transference or

> extra-transference interpretation, to explore the interaction between patient and analyst, so as to see the nature of their contact. We should ask, importantly, whether the analyst's technique wards off rather than permits the entry of what is new and disturbing, and whether the type of movement being made by patient and analyst is towards or away from "trying to know". (O'Shaughnessy, 1992, p. 609)

An important reason for the predicament of psychoanalysis at this historical moment has been its failure to listen to, embrace, address, and redress attempts by feminists, people whose sexual orientation is not heterosexual, people who identify as trans, BAME people, and even scholars of other disciplines to question some of its assumptions. In this way, the discipline has become an enclave, finding what it expects to find in its objects of enquiry and scotomising anything that does not fit. In this turning of a blind eye, it perpetuates the very trap that it purports to elucidate. As a discipline, psychoanalysis has tended to regard attempts to engage with other disciplines with suspicion, as excursions into the dubious territory of "applied" analysis that take us away from the familiarity of "pure" analytic work. This attitude masks fear of the unknown and of being unsettled by what we discover, and, alongside this, an anxiety that it will turn out that we do not have much to offer. The truth is that we have much to learn from our challengers, including sociologists, cultural theorists, historians, child developmentalists, and neuroscientists, as well as having much to offer, if we can learn how to engage in a mutually respectful way.

What is true for the individual is true for the discipline: our growth depends on permitting the entry of what may feel new and disturbing, and engaging with curiosity with those who historically have been excluded and marginalised, and we will not be able to do this effectively unless we also analyse and come to terms with our own reluctance – difficult and unpleasant though this may be. In *Remembering, Repeating and Working-Through*, Freud stressed that the patient must give up his ostrich-like attitude to his illness and

> must find the courage to direct his attention to the phenomena of his illness. His illness itself must no longer seem to him contemptible, but must become an enemy worthy of his mettle, a piece of his personality, which has solid ground for its existence and out of which things of value for his future life have to be derived. (Freud, 1914, p. 152)

It is easy to feel that phenomena such as racism, sexism, homophobia, and transphobia are contemptible, but they are more likely to be addressed in a lasting way if their unconscious roots are taken seriously and there is recognition that an ongoing struggle will be required. Here, psychoanalysis potentially has major contributions to make, but we will increase our

chances of success if we allow ourselves to benefit from the insights of scholars from other disciplines who are also working in these areas.

In his autobiography, Carl Jung described how Freud once refused to accept his help with interpreting a dream he had had:

> Freud had a dream – I would not think it right to air the problem it involved. I interpreted it as best I could, but added that a great deal more could be said about it if he would supply me with some additional details from his private life. Freud's response to these words was a curious look – a look of the utmost suspicion. Then he said, "But I cannot risk my authority!" That sentence burned itself into my memory; and in it the end of our relationship was already foreshadowed. Freud was placing personal authority above truth. (Jung, 1963, p. 158)

Whether or not this story is true, we would argue that the future of psychoanalysis depends on us being prepared to risk our authority by engaging with other disciplines in pursuit of shared interests. If we fail to do this, atrophy, decline, and eventually extinction will result. In his last published words, Bion recognised how dangerous it can feel to give up the recourse to authority:

> Will psychoanalysts study the living mind? Or is the authority of Freud to be used as a deterrent, a barrier to studying people? The revolutionary becomes respectable – a barrier against revolution. The invasion of the animal by a germ or "anticipation" of a means of accurate thinking, is resented by the feelings already in possession. That war has not ceased yet. (Bion, 1979, p. 145)

Yet, Bion's use of the word "germ" evokes new life as well as illness and contagion. The "war" is the struggle to which we have to commit to allow this inevitably disruptive growth to take place – personally, but also collectively and institutionally. We hope this book has convinced you both that psychoanalysis is worth saving and that it has great potential for growth, and that some of our new generation of readers will enthusiastically – joyfully even – commit themselves to entering the fray.

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