The progressive development of Kleinian ideas has resulted in new views of the therapeutic process; thence modifications in technique have occurred and, in turn, further theoretical advances. The discoveries and developments that formed the body of Part II rested largely on investigations of the aggressive component of human life and relationships which flowered from the new play technique for children. The further development of Kleinian practice which will be discussed in Part III has clustered loosely around investigations of the human desire for knowledge (the epistemophilic instinct) deriving from work with schizophrenic patients; the practice of self-knowledge that is the core of psychoanalysis; the structure of the personality elaborating the internal struggle with the death instinct; and the detailed examination of the psychoanalytic process between two people. Broadly speaking, we are moving on to the progress that has been made since Klein’s death in 1960; though influences spread freely across that particular threshold year, in particular the Kleinian reaction to new ways of looking at the transference and countertransference.

Around 1949–50, ‘countertransference’ suddenly came to be conceived differently across the whole of the international psychoanalytic community. Previously, the orthodox view was that of Freud (1910), though he wrote very little about it. He regarded countertransference merely as an emotional reaction to overcome the psychoanalyst’s own complexes and internal resistances evoked by the patient’s transference. In meeting the intensity of a patient’s transference, the psychoanalyst may become emotionally...
involved with the patient. The psychoanalyst may fall in love with a patient who falls in love with him, and so on; or he may find that he hates the patient who expresses hate towards him. In order to protect himself from the effects of the patient’s transference, Freud recommended a neutral stance, comparing it with the surgeon who has to cut and mutilate without flinching; or with a mirror whose only feature is a reflected image of the patient. This tended to make psychoanalysts believe that the proper attitude to their feelings was to abolish them. From about 1920 onwards, every newly trained psychoanalyst was required to have their own therapeutic psychoanalysis to help dissolve complexes and resistances from their work. At the time, in fact, it was called a ‘control analysis’. The ideal analyst was likened to a blank screen on which the patient will discover a transferred object.

By the late 1940s, despite these control analyses, there must have been many well-analysed psychoanalysts who still had their feelings about patients. The ‘blank screen’ did not seem to exist. A reaction set in. Psychoanalysts in several countries argued against the mechanical ‘blank screen’ concept of the analyst’s technique (Winnicott, 1947; Racker, 1949; Berman, 1949; Heimann, 1950; Annie Reich 1951; Little, 1951; Gitelson, 1952). This was a critical thrust against the recommendation of a contrived, cool detachment.

To some extent psychoanalysts were attracted to the new ideas about countertransference because they added depth to the bare form of symbol interpretation which had become standard since Freud’s *Interpretation of Dreams*. Simple interpretations of the form ‘This is a phallic object’, or ‘I am your father-figure’ sounded increasingly banal as patients arriving for treatment were drawn more and more from backgrounds where they gained a sophisticated knowledge of psychoanalytic ideas. That knowledge, I think, must have been one factor that led psychoanalysts to look again at the nature of countertransference, and at the nature of the process they were engaged upon with their patients.

The relationship between analyst and patient is ‘not the presence of feelings in one partner and their absence in the other, the analyst’ (Heimann, 1960, p. 152). With this realization, a more human understanding of the encounter suddenly erupted. The psychoanalyst’s response can never actually be neutral. Nor is it useless:

My thesis is that the analyst’s emotional response to his patient within the analytic situation represents one of the most important tools for his work. The analyst’s countertransference is an instrument of research into the patient’s unconscious. (Heimann, 1950, p. 74)

The point of the relationship between the analyst and the patient is the *degree* of feeling the analyst experiences and the *use* he makes of his feelings . . . The aim of the analyst’s own analysis is not to turn him into a mechanical brain which can produce interpretations on the basis of a purely intellectual procedure, but to enable him to sustain his feelings as opposed to discharging them like the patient. (Heimann, 1960, p. 152)

At the time, this was a radically new injunction: if the analyst can sustain feelings, they are positively useful, whereas discharging them could be damaging and certainly clouds the issue. For instance, the analyst may feel angry with the patient. He could then discharge feelings, perhaps, by having a go at the patient – giving the patient ‘a piece of his mind’, we might say. Or the analyst may feel overly positive, even erotic, towards the patient, and might then freeze up and perform the legendary emotionless blank screen. Alternatively, however, the analyst could hang on to those feelings, acknowledge whose they are, but understand how they have come about. This will inevitably tell something about the patient to whom the psychoanalyst is reacting. Of course it must also tell something about the analyst as well – provided the analyst is prepared to consider his feeling (rather than discharging it). But whatever the reaction in the analyst, there is something of the patient to which he reacts – and, as we shall see, whatever the patient’s experience, there is very often something of the analyst to react to. It is the patient’s contribution, however, that both need to attend to for the progress of a psychoanalysis. It is the analyst’s contribution which can give clues about the patient’s contribution, provided he can rely on his self-understanding. Such provisos, of course, can be only partially met by even the most insightful psychoanalysts; and later we will see moments when even the analyst’s lapses may be turned to benefit an understanding of what is going on.

In this chapter, I want to examine how this new understanding of countertransference has been developed by Kleinians. It has come to be seen as a dialogue between two unconscious minds,
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with the conscious exchanges mediating the unconscious ones. In the first example, below, Heimann shows in a tiny detail from the end of a session how the new notion of countertransference can be a tool for understanding the transference relationship. We met this strange patient in the example of The man who assaulted his buttocks (p. 66). In the next example a sudden emotional impact on the analyst as the session ended revealed an important feature of how he related to his objects. It was not very easy for the analyst. Mostly, in ordinary social life, such impacts would be dismissed out of a kindly tolerance, without much thought; or responded to by keeping more of a distance from that person in the future. We can see, however, that by hanging on to the response without discharging it through a dismissal or an avoidance, an analyst can come to know something more about the patient.

Example: The introjection of the analyst

This patient, described by Heimann, often conveyed his love and admiration for his mother because of her kindness, and particularly her forbearance. For instance, he remembered how he once took her into his car and drove off with her, and how, when they had gone a good distance from home, he unburdened himself by accusing her of the many wrongs he felt she had done him.

She had listened patiently and with her characteristic kindness.

The analyst is emphasising to us the patient's story of how he takes his mother (like his father, described in The man who assaulted his buttocks) inside him (into his car) and then makes her suffer there as an internal object. Heimann then described one particular session which began as the usual report of his miseries - in his life and in his psychoanalysis. It then flowed on to a current life problem, though he seemed unwilling to subject this to the process of psychoanalysis:

He demanded that analysis, which in his view had utterly failed to improve his condition, should now be put aside, that I should give him advice about the 'real' problem which was so pressing, and intervene directly in his external situation. I did not comply with his demand, but proceeded in the ordinary way; and he became less anxious and less persecuted and also gained more understanding.

We are shown the patient trying to take the psychoanalyst outside the analysis, to demonstrate how (in the transference) the patient re-enacts his relations with his mother, whom he took away in his car to unburden himself of the wrongs he has suffered. The analyst, like the mother, continued patiently:

His attacks on the analysis and on me, and his pleasure in insulting and accusing me, seemed rather stronger, perhaps, than usual; and on leaving, though much relieved and with more insight about his actual problem, he stated that I had not helped him at all and that he would be as much tormented after the hour as he had been before it.

His claims against the psychoanalyst seemed invalid to her, as he had in fact been relieved and gained more insight. So what does it mean to the patient to deny that he has had a good experience? Heimann focuses on his manner of stating his complaints:

The way, however, in which he made this statement did not accord with an anticipation of misery. It was with relish that he flung this parting shot at me. The effect accompanying his remark was triumphant and menacing.

Let me emphasize the impression we are now offered: it seems that the patient was more intent on having an effect on his object, the psychoanalyst, than on communicating with her in the content of his words:

Manifestly his words contained two statements, one about my failure to help him and the other about the condition of torment he foresaw for himself. The hostile triumph in his attitude clearly related to the first statement - my failure as an analyst - and was in line with the many scornful remarks he had so often made; but in connection with the second part of his remark another message emerges. There was also an unmistakable threat in his attitude, which, if put into words, would run like this: 'I shall torment you after the hour exactly as I have done here. You cannot escape from me!'

The patient was indeed successful in having an effect on the analyst. She picked up, intuitively, an emotional moment. I think this conveys how the analyst is beginning to understand her own reaction as the patient's intention. He sought to threaten her, and to send her away from the session to continue her suffering - as a failed analyst:

The unconscious meaning of the patient's parting words was that I was going to suffer. What he had said about himself unconsciously related
to his object, which he could triumphantly control and torment because he had introjected it.

He predicted his own suffering; and he was correct, but only in the specific internal sense – he would continue the masochistic kind of beating described in the earlier account of this patient. However, some aspect of himself had become identified with the psychoanalyst who will be made to suffer inside him:

It takes much longer to describe than to perceive a process which takes place in a moment. It seemed to me that I could actually witness in operation the process of the patient's introjection of myself.

The analyst has constructed a narrative in which this man introjected his object and then subjected it to some sort of torture inside, as an internal object. She became aware of the patient's effect on her, and could hold on to it and think about it. She could then piece together two things: first, the content of the explicit story about taking mother for a ride; second, the momentary emotional impact on her (the countertransference). It is the psychoanalyst's work to set these two things beside each other: the content of the patient's material; and the countertransference experience and feelings. Each can support the other; in this case the picture of what happened in the car could be mapped onto the experience within the psychoanalytic session.

At this stage I am not making any point about the greater acuity of the analyst's sight of this immediate process; we will come on to that later. Nor do I want to comment on the analyst's contribution to her reaction, since that is not conveyed in the material Paula Heimann gave. However, we will begin to see how the internal worlds of both psychoanalyst and patient meet and reverberate together when we come on to the next example, The abusing patient (p. 160). Before that, however, I will make some general comments about this developing form of practice.

When the psychoanalyst does not bring the two elements – content and countertransference – into conjunction, there is the danger of rather wild interpretation. Heimann worried about this later, and felt that her original recommendations (1950) were at times taken up in a misleading and unhelpful way. She argued (in 1960) that some psychoanalysts based their interpretations on their feelings. They said in reply to any query 'my countertransference', and seemed disinclined to check their interpretations against the actual data in the analytic session. (Heimann, 1960, p. 153)

Banal interpretations on the basis 'because it felt right' could become as mechanical as the 'this is a phallic symbol' interpretation. Countertransference feelings alone are not the basis for an interpretation – just as interpretation of symbolic content can no longer stand alone either. Both have to be interwoven together to support each other. The countertransference deepens the symbol interpretation; the symbolic content steadies and directs the understanding of the countertransference. This mutuality between content and transference/countertransference is important.

Because of the risk of the wild use of the countertransference, Heimann's original paper in 1950 was not graced with Klein's approval. It seems to have led to the break between Heimann and Klein, despite Heimann's later warnings of these risks.

Cycles of Projection and Introjection

Many Kleinians, however, did become interested in the countertransference as an aspect of the analytic relationship. They retained an intrapsychic view of what happens within the patient's psychic life, based on cycles of alternating introjection and projection. This is then linked with an intrapsychic view of what happens in the psychoanalyst's psyche too.

In what Roger Money-Kyrle (1956) called 'normal countertransference', cycles of projection and introjection go around smoothly in both psychoanalyst and patient without undue delay. The patient comes to the analytic session with something on his or her mind, and conveys the experience. This is more than passing information over to the analyst about various happenings, or about a state of mind; such reports invariably convey to the analyst in a more direct way what the experience actually feels like. What is on the subject's mind is, in effect, projected into the analyst's to create an impact there. The analyst then has an experience, which consequently comes to be 'on his mind' too.

Consider a patient bringing particularly good or particularly bad news; say, the birth of a new baby or a death in the family. Whilst such an event may raise complex issues requiring careful analysis, in the first
instance the patient may not want an interpretation, but a response: the sharing of pleasure or grief. And this may be what the analyst intuitively wishes for too. (Brennan Pick, 1985, p. 39–40)

The analyst does not simply listen to the news of the birth of a baby as a mere news report. The analyst has an experience with the patient; intrapsychically, we would describe it as follows: the analyst introjects what the patient has projected. It is not necessarily a violent, omnipotent form of projection as described above with the psychotic patients. Indeed, this process of gently giving another person an experience which they can savour is a normal part of conversation in general and, among other things, is what makes social contact enjoyable.

When the analyst has grasped the experience, he or she is in a position to say, 'I know how you feel', though an analyst does not say it exactly like that. The analyst puts into words an understanding of what the patient is feeling, especially the patient's unconscious experiences and phantasies. In those cases where the projection is of a more desperate nature, the analyst may have a much greater difficulty in recognizing what experience has been projected. Nevertheless, in those cases the analyst still plays the part of disentangling what she or he has received. If this disentangling is successful, the patient's original experience is thus modified - Money-Kyrle (1956) called it 'metabolized', to make the analogy with a physical process of taking in and digesting. The analyst's understanding gives the patient's experience a new shape, a more communicable shape. What can be conveyed only implicitly or vaguely by the patient through projection is changed or focused by the psychoanalyst's mind. The psychoanalyst must then find a way of announcing this to the patient. A verbal formulation of the original experience is put back to the patient, but now modified by transmission through the analyst's mind. Putting it back to the patient in words attempts to achieve a gentler form of projection by the analyst into the patient; it is in fact likely, and intended, to have an impact on the patient. The term 'reprojection' suggests itself, to cover the return of something to the patient that had previously been projected into the analyst. The patient may (or may not) introject that conscious understanding. Thus the 'reprojection' is not simply passing information back to the patient – it adds an increment from the analyst's own experience and understanding on to the patient's. The fact that the analyst's mind could work on the experience confirms for the patient that the particular experience does not necessarily clog up the mind; such experiences could then be recognized as thinkable, not merely for discharge. They can, though they are often disturbing, be reflected upon without causing a breakdown. If the patient can accept this, it adds to the stock of self-understanding and mental stability. The 'reprojection' by the analyst then becomes an addition to the patient which can be called an 'introjection' by the patient.

This kind of account describes the intrapsychic occurrences of both patient and psychoanalyst. From the patient's point of view his or her intrapsychic world interacts with the world outside; but that world outside is the intrapsychic world of someone else. This focus on the intrapsychic qualities of interpersonal interactions often leads to criticism that Kleinian psychoanalysts neglect reality. In a sense they do, since external 'reality' for one person is the internal world of others. This approach has a disturbingly fluid quality that disrupts any sense of reality being a constant. In this view the interpersonal world is not like the physical world of inanimate matter. This is a complicated issue that has far-reaching implications well outside psychoanalysis. A limited discussion of it will be found in my Dictionary of Kleinian Thought under the heading 'Subjectivity'; and to some extent in my 'Reflections' at the end of this book.

In summary: from an 'intrapsychic' viewpoint the analyst can be said to introject the patient's projection; then to project (or reproject) it back to the patient in a form that bears the marks of the analyst's own mental work on it: the patient introjects the now-modified (metabolized) experience, together with an added capacity to 'understand himself', and thus to 'stand himself'.

**When Countertransference Goes Wrong**

We touched on the complicated process when the analyst/mother fails to take in (contain) in Bion's descriptions of it (The mother who could not understand, p. 127; The cheated patient, p. 130; and The patient's failed container, p. 131). There are a number of accounts of these cyclical processes. Here we will follow Roger Money-Kyrle's (1956). His invented fiction the 'normal countertransference' was intended to clarify the variations and deviations
from that 'normal' process summarized in the preceding section. The analyst can go wrong if the emotional material touches on specific difficulties of his or her own; then she or he may get stuck in the cycle: either in the first phase, when he or she is projected into and so becomes full of, and bothered about, the patient's experience; or in the second, when reprojecting may discharge so much of the analyst's mind that he or she feels depleted.

If the first phase goes wrong, the patient projects and the analyst is burdened with an internal object that is then inadequately held on to and thought about:

the analyst gets unduly worried, both on his own and his patient's behalf, about a session that has gone badly. He may feel as if he has regained some of his old troubles and become almost physically burdened with his patient's as well. (Money-Kyrle, 1956, pp. 25-6)

Or, secondly, when interpreting, the analyst excessively reprojects back into the patient:

... for a little time after he has finished his week's work, the analyst may be consciously preoccupied with some unsolved problem of his patient's. Then he forgets them; but the period of conscious concern is followed by a period of listlessness in which he is depleted of the private interests that usually occupy his leisure. I suggest this because, in phantasy, he has projected parts of himself together with his patients and must wait, as it were, till these return to him. (Money-Kyrle, 1956, p. 26)

The two phases in which the analyst might get stuck - either introjectively burdened with the patient or depleted through excessive projection into the patient - both lead, Money-Kyrle pointed out, to a triple task: it is necessary to discern (a) the analyst's disturbance; (b) what the patient has contributed to it; and (c) how the analyst's stuckness has then affected the patient. To illustrate, Money-Kyrle described a neurotic patient who disturbed the psychoanalyst's mind.

Example: The abusing patient

The patient arrived for his analytic session very anxious about his work:

Remembering a similar occasion, on which he had felt depersonalized over a weekend and dreamed that he had left his 'radar' set in a shop and would be unable to get it before Monday, I thought he had, in
But he [the patient] was in the same mood at the beginning of the next one - still very angry and contemptuous.

The patient returned to his next session still stuck in his projective phase:

I then told him I thought he felt he had reduced me to the state of useless vagueness he himself had been in, and that he felt he had done this by having me 'on the mat', asking questions and rejecting the answers, in the way his legal father did.

So we see the psychoanalyst recovering and able to gather his words; but it is not the original situation he describes, it is now too late for that: 'it was useless to try to pick up the thread where I had dropped it. A new situation had arisen which had affected us both.'

It was this new situation which had to be interpreted, the way the psychoanalyst had given the patient the opportunity to exploit his rumbling in order to express (communicate) something of the patient's own feeling of useless vagueness, and the way it had rendered the patient free of his unpleasant state of mind:

His response was striking. For the first time in two days, he became quiet and thoughtful.

The reader is now accustomed to the importance of this response. The patient's demeanour changed abruptly to become quieter and more thoughtful. Please note also the change in the capacity for thought. Once the psychoanalyst could reflect on his experience and sort it out in words, the patient had gained a significant addition to his own capacity to think about his experience:

He then said this explained why he had been so angry with me yesterday: he felt that all my interpretations referred to my illness and not to his.

I think it is clear that the patient has suddenly acquired a new power to capture his own view of the situation, rather than simply reacting to it with vehement protest against the analyst. We would find it difficult to contest the analyst's view that the interpretation struck a note of truth for the patient and restored some of his mental functioning.

This step-by-step, 'slow-motion' account describes how the patient's projection had fitted in with some problem of the analyst, who then began to identify with it and become disturbed by it. He could not handle the experience properly - at least, not at first - and, like the patient, he became overwhelmed by it. The analyst ended up simply stuck with the feeling of uselessness and vagueness. To retrieve the situation, he had to do a silent piece of self-analysis involving the discrimination of two things which can be felt to be very similar: my own sense of incompetence at having lost the thread, and my patient's contempt for his impotent self, which he felt to be in me.

This discrimination is a very crucial point. One aspect of the patient and another aspect of the analyst met together in the analyst, and the confusion of identity (who was ill?) needed disentangling, since in a sense, both were ill at that moment.

Let us consider this from another angle, one with which we are already familiar. It concerns the quality of the projection - the degree of violence involved. When the subject - patient or analyst - employs great violence in his unconscious phantasy, the result is more likely to be an entangling confusion within the mind of the other person. The aim, at least, is for the analyst to perform his reprojection with less violence than his patient originally used. If he succeeds, the whole bundle of mental qualities summarized in the Epilogue to Part II will be shifted a little to the right of the table (see p. 148).

THE MEETING OF MINDS

Not only does the psychoanalyst have human responses, however, but the patient may well surmise that he is bound to have them. He then wonders what the analyst is doing with them. All the time the patient is seeking out a responding analyst: for instance, 'the patient projects into the analyst's wish to be a mother' (Brenman Pick, 1985, p. 41). Indeed, being 'something like a mother' is often a significant motivation to become a psychoanalyst or psychotherapist in the first place, and patients may correctly spot this. Then they can use it in certain ways: perhaps to gain the satisfactions of being mothered, which they have felt the lack of; or perhaps to find a way of giving good feelings to the analyst; or possibly to create a feeling of controlling the analyst's mind, and so on.

Irma Brenman Pick expanded this into a general property: 'If there is a mouth that seeks a nipple as an inborn potential, there is, I believe, a psychological equivalent, i.e. a state of mind which seeks another state of mind' (Brenman Pick, 1985, p. 35). As we
noted above, at the psychological level the reality the patient relates to is the internal world of another, the psychoanalyst. When the analyst is affected by the patient’s material and by the patient’s state of mind, he or she is required to respond calmly. The dilemma of providing calm reflection when disturbed is one the analyst faces all the time: if ‘we take in the experience of the patient, we cannot do so without also having an experience’ (Brenman Pick, 1985, p. 35). To face it with calm reflection requires considerable emotional resilience and the powers to work it through:

One great difficulty in our work is in this dual area of remaining in contact with the importance of our own experience as well as our allegiance to the profound value of our technique . . . I think this problem applies, for instance, to the controversial issue of interpretation versus response . . . the issue becomes polarized, as though one was all good, the other all bad. (Brenman Pick, 1985, p. 40)

The analyst constantly risks toppling off this knife-edge either into a method of cold rational automatism (the blank screen approach) or to acting upon his or her own responses to the patient ‘because it felt right’ (in the manner Heimann warned against – see above).

There is only one resolution to the controversy over interpretation versus response: the content of the interpretation must take account of the response in the analyst as well as the content of the patient’s material:

Unless we can properly acknowledge this [the analyst’s anticipated or actual response] in our interpretation, interpretation itself either becomes a frozen rejection, or is abandoned and we feel compelled to act non-interpretatively and be ‘human’. (Brenman Pick, 1985, p. 40)

So – merely ‘being human’ risks conforming to figures based on the splitting of objects into ‘good’ ones and ‘bad’ ones – a retreat from the painful mixtures of the depressive position. In the next example the bad aspects of mothering were relegated to family, spouse and past objects, and so on, away from the session and the person of the psychoanalyst. The analyst becomes the good satisfying mother – better than all the others. Both patient and analyst may enjoy that fiction. There is potential here for a stuck state, with the patient projecting a perfect mother into the analyst’s wish to be one. Without this transaction ever reaching proper conscious and verbal articulation, the psychoanalysis, though enjoyable to both, is rendered stuck. The next example shows the analyst’s struggle to think this through.

Example: The man who was sensible

Mr A, described by Irma Brenman Pick, had come to London after a psychoanalysis abroad:

He arrived for his session a few hours after having been involved in a car accident in which his stationary car was hit and badly damaged: he himself missed being severely injured. He was clearly still in a state of shock, yet he did not speak of shock or fear. Instead he explained with excessive care what had taken place, and the correct steps taken by him before and after the collision. He went on to say that by chance his mother (who lives in the same country as the previous analyst) phoned soon after the accident, and when told about it responded with ‘I wouldn’t have phoned if I had known you’d have such awful news. I don’t want to hear about it’. He said that thanks to his previous analysis, he knew that he needed to understand that his mother could not do otherwise, and he accepted that.

We are presented, as is the psychoanalyst, with a very cooperative-sounding patient who knows how to deal with a shock. The patient is very aware of the impact of ‘bad news’ on his mother, who does not want to listen to it, and how important his ‘understandingness’ is to her and to his previous analyst.

He was however very angry with the other driver, and was belligerent in his contention that he would pursue, if necessary to court, his conviction that he would have to pay for the damage.

Despite his understandingness he can also feel a quick, litigious grievance:

I believe that he conveyed very vividly his belief that he would have to bear alone or be above the immediate shock, fear and rage generated both by the accident and the mother’s response to it. Not only did he believe that his mother did not want to hear the awful news, but that the analyst did not want to hear the awful news of there being a mother/analyst who does not listen to or share pain with him. Instead he felt he had been taught to ‘understand’ the mother or listen to the analyst with an angry undercurrent that the mother/analyst will not listen to his distress.

The patient’s protectiveness towards his mother is clear enough; and that is why he is so understanding. But the analyst is also telling us that the patient finds an analyst, too, who similarly will not want to hear bad news. Do we follow Brenman Pick in this step? The
point is that the patient talks so calmly to this analyst when actually he is distressed, and this must imply that he thinks she, too, could not bear a distressed patient. One could say that, in effect, he does not properly use the analyst to project the distress about the car accident into. Like his previous one, this analyst will demand his understanding rather than his grievance. But unconsciously, there is another attitude:

He went along with this, pulled himself together, made a display of behaving correctly, became a so-called 'understanding' person. He replaced the distress of bearing pain with competence in doing the right thing, but let us know that unconsciously he will pursue his grievances to the bitter end.

This patient is splitting his object: between the analyst he must understand and protect, and the one whom unconsciously he will grievously accuse:

Now let us consider what took place in the session. The patient made an impact in his 'competent' way of dealing with his feelings, yet he also conveyed a wish for there to be an analyst/mother who would take his fear and his rage. I interpreted the yearning for someone who will not put down the phone, but instead will take in and understand what this unexpected impact feels like . . .

So the present psychoanalyst did feel some impact from the patient - he made one kind of projection; it was to project not his shock, but his loneliness. And she can tell us (now) that presenting his loneliness through his stoical 'understandingness' did affect her maternal feelings and sympathy:

... this supposes the transference onto the analyst of a more understanding maternal figure. I believe, though, that this 'mates' with some part of the analyst that may wish to 'mother' the patient in such a situation.

She took in not just the situation in which a son felt hopelessly lonely: more importantly she also took in a responsive kind of 'mother' who can feel for the patient's loneliness. And that 'good' mother fused with her own maternal feelings. It seems natural enough to respond like this; but Brenman Pick regarded her own reaction a little suspiciously:

I had been lured into either admiring the sensible, competent approach, or appearing to condemn it. I found that I was having the experience of feeling superior to and judging the mother, previous analyst and his own 'competence'.

She noticed from her own reactions that the patient had found a particular aspect of the internal mother in the psychoanalyst to project into - an aspect that can feel better than the others. Brenman Pick noticed her own superiority: that she could mother 'better' than the patient's own mother; better also than his previous psychoanalyst, who also seemed to imply that competence was what was needed from the patient; and better than the patient's internal mother, who demanded competence of him. Brenman Pick found herself happily embroiled in a splitting between herself, a thoroughly 'good' mother, and all those 'bad' ones:

Was I being party to taking them all to court? ... I then needed to show him that he believed, in presenting me with such an awful picture of a mother/analyst, he persuaded me to believe that I was different from and better than them.

She eventually realized that her superiority connected with the patient's invitation to her to be the best of all mothers. In this way the analyst had joined the patient in a pattern of interaction which seemed perfectly sensible to him; and indeed, at some level, to her. The problem is that it merely contributes to repeating the patient's expectations. Those expectations, which derive from the use of his splitting mechanisms in the transference, need to be understood rather than repeated.

Brenman Pick believed that the patient could actively promote this situation; that he would have some awareness of what a mother will feel. He believed that his own mother did not want to hear bad news, and froze off, and he seems to have been right about this. Yet he also has some idea of an ideal mother, which he looks for by seeking out the psychoanalyst's responses. Brenman Pick invites the question: should she respond or interpret? When she responds to his yearning to be listened to sympathetically, she claims, they repeat his pattern of splitting. Moreover, she would claim that this deeply buried enactment must be a transference pattern of a habitual kind, and that the patient is better served by helping him to understand that he can have a choice whether or not to persist with projective manoeuvres in other people's minds.

The proper task, therefore, is to acknowledge this response in an interpretation: 'The point is we have to cope with feelings and
subject them to thought' (Brenman Pick, 1985, p. 41). This conforms to Heimann's injunction that the analyst 'sustain his feelings as opposed to discharging them like the patient' (Heimann, 1960, p. 152). Both Money-Kyrle and Brenman Pick imply that psychoanalysts (and therefore psychoanalysis itself) are not perfect; they make mistakes, and have mixtures of feelings and motives (the depressive position). Like the patient, they have desires: 'to eliminate discomfort as well as to communicate and share experience; ordinary human reactions. In part the patient seeks an enacting response, and in part, the analyst has an impulse to enact, and some of this will be expressed in the interpretation' (Brenman Pick, 1985, p. 36). About her own slipping into her motherly role, she says: 'If we cannot take in and think about such a reaction in ourselves [i.e. the wish to mother], we either act out by indulging the patient with actual mothering (this may be done in verbal or other sympathetic gestures) or we may become so frightened of doing this, that we freeze and do not reach the patient's wish to be mothered' (ibid., p. 38). Brenman Pick has amplified the moments of stuckness to which Money-Kyrle pointed, with the details of 'mating' of a specific part of the analyst's personality (which the patient gets to know extremely well) with a certain aspect of the patient.

The Available Parts of the Psychoanalyst

Brenman Pick, in asserting how a 'state of mind [which] seeks another state of mind' as a mouth seeks a nipple, suggests a very important model for understanding the transference/counter-transference interactions; and for helping with the 'little piece of self-analysis' that is required to disentangle stuck situations. The psychoanalyst is required to know the parts of him-or herself which are vulnerable and available to be projected into. Motherliness is clearly one obvious possibility, since most psychoanalysts are in the business of trying to feel for others and reducing their distress. Every analyst will have a variant on this. Most will find themselves becoming reassuring at times, or giving advice to their unhappy patients. Every analyst will also have many other aspects with which the patient will link in this way. Each one of us is a unique personality, and will have unique aspects ready to respond. There are certain common ones: the analyst's super-ego, for example; the

patient will expect, and often get, criticism, usually unintentional and unwitting, from the analyst. Another is the sexual aspect of the analyst, and perhaps this was the first of all these kinds of links to be noticed - Josef Breuer, in the treatment he conducted in 1882, froze over so completely when his patient, Anna O, fell in love with him that he backed out of the whole project of psychoanalysis altogether, leaving Freud to go on alone.

These problems obstructing the understanding of what is happening in the intrapsychic world of the patient arise from the psychoanalyst's mind becoming overrun by disturbance; the psychoanalyst's own disturbance mating with that of the patient. In a sense the analyst could be said to know about the disturbance, but is not able at such times to know about it usefully for the patient.

There may, however, be some aspect of the patient that aims specifically to disrupt this link of 'knowing' in the psychoanalytic pair. In subsequent chapters we will come on to the ways in which the patient may exploit the psychoanalyst's efforts to know. In the next two chapters I propose to take us through the very important developments in understanding the processes of knowing and thinking, and what goes wrong with them.