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: 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 presenting to the analyst which may cause particular difficulty. We can offer no simple answer to these problems. Psychoanalysis cannot be 'manualised', and indeed the attempt to do so even with short-term therapies is fraught with difficulty (Fretter *et al.* 1994). There is not a unique, correct, solution. Each patient has to be treated according to his particular circumstances. Every analyst deals with complex clinical situations from experience based on his own analysis, knowledge gleaned in 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. It is especially important to remember that each difficulty has a particular meaning to patient and analyst within the context of the analytic process.

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

First, there are problems which interfere with the overall *continuity* of the sessions but do not immediately threaten the actual treatment

Table 9.1 Classification of clinical problems

	Enactment		
Continuity	*Acting in*	*Acting out*	*Special groups*
Absence	Physical contact	Suicide	Adolescents
Lateness	Persistent questions	Self-mutilation	Elderly
Breaks	Presents	Drug abuse Alcohol abuse	Medication
Impasse	Money		
Family	Silence		Eating disorder Training patients Ethnicity Previous analysis

itself – for example, non-attendance, lateness, breaks and the so-called 'therapeutic impasse'. Second, there are *enactments*, which may be *within* a session, known as 'acting in', such as excessive or inappropriate demands, regular present giving, problems around fees and silence on the part of the patient. Enactments outside the session present the most serious challenge to the analyst and may threaten the treatment itself. These usually take the form of serious acting out, such as suicide attempts, self-mutilation and drug abuse. Finally, there are *groups of patients* that present particular difficulties – for example, adolescents, borderline patients, patients on psychotropic medication, patients suffering from eating disorders, elderly patients, candidates in psychotherapeutic or analytic training, those from ethnic minority groups and those 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 acts out is also likely to act in, the one 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 p. 164) and will always need to be addressed if an analysis is to

progress. All 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 'overdetermined', each having its own coherence at a particular level of interpretation (Breuer and Freud 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 doesn't wish to talk about something. More often, he finds himself arriving late for a variety of apparently unavoidable reasons. Apologies are given and the session continues normally. The analyst needs to make a mental note of the lateness and listen carefully to the material. 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 manifest 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 wouldn't 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 couldn't 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 reasons behind their rigidity may only become clear after years in analysis! In these cases, it is the rigidity rather than the lateness itself that suggests the pattern is defensive in nature and 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 wasn't up to the analyst to dictate when the session was going to start; it was his prerogative. Further work showed 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 were 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.

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 only became available for analysis when threatened by the analyst's lateness.

Breaks

Breaks in treatment at weekends, for holidays, or unavoidable commitments on the part of both the analyst and 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. To these patients the analysis is in some way a chore, a requirement, and they struggle under a feeling of oppression by the analyst. In their mind the analyst is a critical superego figure, always ready to comment adversely on their behaviour and fantasies. Weekends and breaks become a freedom that is relished. 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 an abandonment. One patient secretly tape-recorded Friday sessions, playing them back to herself throughout the weekend; another would reluctantly leave the Friday session and go to bed for the whole weekend, only able to come alive again on Monday morning. For some the break symbolises primitive feelings of abandonment; 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.

Patterns emerge over weeks and months. Only after they are 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 p. 162) may refuse to leave the consulting room. Here, a reality based statement 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' may help. The analyst has to assess the patient's capacity to manage over a break or weekend and may need the help of another mental health worker or the patient's general practitioner. In general it is best to anticipate such difficulties and to make appropriate arrangements well in advance, always considering the unconscious meaning of such extra-analytic actions (Stewart 1977). The bipersonal field (Langs 1978: p. 116) is never more in stark relief than when the analyst has to take on a management role.

Some analysts send their patients a post-card 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 post-card 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 whether from an exotic location or from a local area. The analyst should remember that he has sent the post-card or written the letter when the sessions resume, and to listen out for its effect on the patient.

Example: human contact

A borderline patient, feeling terribly frightened by a forthcoming month-long break, complained of being abandoned and uncared for. She experienced her analyst as sending her away. 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 post-card during the vacation to bridge the gap and to help continuity of the analytic relationship, 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 interpretation 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 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 changes and develops. 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. Rosenfeld (1987) ascribes most blockages in the patient–analyst interaction to the analyst's unconscious infantile anxieties. In order 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, the analyst has to examine very carefully his own feelings and look for hints of collusion between himself and his patient.

It is important to distinguish an impasse from a negative therapeutic reaction (see p. 165) which follows a period of progress. A true impasse develops slowly, almost imperceptibly, and is only recognised when the analysis remains static or the patient seems

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 finishing treatment. At this time he takes responsibility for his guilt and badness but, rather than experiencing feelings of remorse and facing independence, he remains static. He prefers to use the analyst as a permanent prop. He is symptomatically better and can appreciate the help he has been given but continues to be preoccupied by his own well-being at the expense of his objects. Equally, an impasse based on 'reversible perspective' (Bion 1963) may be so subtle as to be undetected. Reversible perspective consists of manifest agreement between patient and analyst but latent disagreement and hostility. The patient seems to come for one purpose, but in reality has a covert agenda, e.g. to placate a partner, make social contact, or as part of a career plan in psychiatry or psychotherapy.

But what should the analyst do in these situations? Interpretation has already been shown to be ineffective. Sometimes it may be necessary 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. At these times 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 infused with countertransference and such a move is probably best done only after discussion with a colleague. Supervision is essential in this situation.

ENACTMENT: ACTING IN

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

Physical contact

Requests from patients range from the relatively benign, such as questions and requests to change sessions, to the more problematic such as demands for *physical contact*. Occasionally the analyst may be 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 p. 109) may be unperturbed by the analyst's refusal of a tenacious demand 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 his rule of abstinence, even in an attempt to create a more 'holding' environment, the outcome is likely to be disastrous (see 'too close, too soon', p. 230). 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 '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 tenderness from the analyst, appear more reasonable but may represent a subtle denial of aggression.

Careful scrutiny of countertransference and vigilant listening to the patient's material show how acceding to the patient's request may mean that the opportunity for a mutative, albeit painful, experience for both patient and analyst is missed. 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, within the relationship with the analyst, those extreme feelings which belonged to earlier traumatic experiences that were themselves 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, a wound 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.

Balint (1968) states 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 (1986) similarly argues that bonding between a weak individual and an attachment figure can be protective rather than sexual, and therefore that hand-holding is not, as some would argue, inherently seductive.

The patient's family

Patients who create severe difficulties within treatment are also likely to cause problems to other professionals and their families. In the 'basic model' technique of psychoanalysis, relatives are a neglected group often distanced from the treatment in order to protect the therapeutic alliance and the privacy and intimacy of the relationship of patient and analyst. They are viewed as a source of danger, contaminating the aseptic field. Freud (1912a) 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 whether relatives' involvement arises from the patient himself, their 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 borderline patient relied on her husband to stop her from cutting herself and taking overdoses. She had to report in 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 in at a prearranged time, or if he found razors 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 sado-masochistic interaction disguised as caring support. As the analyst and patient began to address this issue, the husband

insisted that he would no longer pay for 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, he agreed. In discussion it was decided that the patient should continue in analysis while they jointly saw a marital therapist. Athough this was an unusual course, it saved the treatment.

There is an increasing tendency for psychoanalysts to treat borderline and narcissistic personalities. A large number of these will become suicidal or self-destructive and others may have drug and alcohol problems. Serious acting out may occur. In these circumstances relatives can be allies rather than enemies. It is often helpful to see a spouse or partner at the initial interview in order to discuss the treatment. If a contract is set up, as may be the case for borderline patients (see p. 232), it is important that both patient and relative agree with 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, the analyst needs to think carefully about what he tells the relatives, in order to protect his relationship with his patient. It is best to discuss this 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 it increases the danger of the analyst basing his treatment on what he perceives as an objective reality rather than on discoveries within the transference.

A request to see the analyst may come directly from the patient's partner rather than from the analyst or patient, especially if the partner feels shut out of the treatment.

Example: too much protection

A 36-year-old man had become seriously depressed and suicidal but 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 round 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 two years suddenly 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, 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 didn't 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 and hatred of the analyst. 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 the analyst, although confidentiality of session material is maintained, or to be offered help in their own right. Nevertheless, in adult analysis, too great an involvement may become defensive on the part of the analyst and detract from enduring and working through conflicts which 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 borderline patient, 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. 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, her husband was invited 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 only wanted to tell her husband of the return of the suicide risk to protect himself from criticism if she killed herself, and because he needed someone else's support in the treatment. The patient's refusal was an implicit statement that 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. 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 when 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.

ENACTMENT: ACTING OUT

Acting out has become an over-inclusive term, often encompassing all behaviours of which the analyst disapproves as well as actions, such as recurrent destructive acts, which form part of an individual's character or personality. In its more restricted sense it refers 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 1940a). Acts within the session, such as walking round the room, hitting the wall, pushing books off the shelf, or actualisation in the transference, have been known as 'acting in' (Eidelberg 1968). Both acting out and acting in are examples of *enactment*. Acting out implies a regression to a prereflective, preverbal level, a belief in the magical effects of action, and a desperate need to get a response from the external world.

The psychoanalytic setting itself therefore encourages acting out by inducing regressive behaviour. Maturity implies integration of action, sublimation, symbolisation and other 'higher' functions. The dis-integration associated with regression is particularly marked in borderline and narcissistic patients (*q.v.* p. 222). 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 (Limentani 1966). Balint (1968) describes a patient who enacted a somersault in her session, ushering in a breakthrough in her analysis. On the negative side it is destructive, personally dangerous or even life-threatening and may jeopardise the analysis; the unconscious internal drama or phantasy passes directly to the outside, circumventing thought and psychological defence, and so gains expression. 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 with a male analyst 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 gave him regular enemas as a small boy. As treatment progressed he became more confident and found himself a girlfriend. At the time at which 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 the analyst, especially when unexpected, and they may induce complementary countertransferential responses. He may apply rules and regulations, sometimes in panic, which 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. If the assessment interview suggests that serious acting out is likely to be a feature of analysis, the analyst needs to draw up a contract with the patient at the beginning of treatment (Kernberg *et al.* 1990; Selzer *et al.* 1987) and not wait until something untoward occurs. Appropriate support, set up before treatment, can be activated while the analysis continues. If unexpected, it presents serious challenges to the analyst, not least of which are his feelings of anger, fear and helplessness. Countertransference responses become crucial.

Bilger (1986) has suggested that the pressure placed on the analyst by the behaviour is the primary factor in its designation as acting out, and believes the central quality is one of transgression of an unspoken boundary.

Example: an intrusive greeting

A 48-year-old depressed man became friendly to the point of obsequiousness soon after starting treatment. After entering the waiting room he would open the consulting room door to say 'hello' to the analyst even if there was another patient there. The analyst felt intruded upon and angry. The patient's act of popping his head round the consulting room door was later understood as a reversal of transference roles in which the patient acted like his mother who continually entered his bedroom when he was a boy to 'see how he was and just to say hello' while the analyst became the angry boy who felt invaded.

Analysts may themselves act out or even enjoy vicariously their patient's misbehaviour, much as a restrained parent may tacitly condone rebellious behaviour in his children. Such countertransferential influence should be considered if acting out escalates despite careful interpretation. Supervision is essential to help the analyst extricate himself from anti-therapeutic involvement.

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 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 by himself or through a third party such as a GP 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, and 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, expressing his willingness to enter into treatment but give no guarantee of success. Kernberg *et al.* (1990) suggest that realistic appraisal with relatives early in treatment, or even before treatment starts, helps to prevent the destructive involvement of relatives, 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 found in suicidal patients. These represent the wish to die, the self-directed wish to kill and the wish to be killed respectively. *Hopelessness* may infuse the analysis to such an extent that the analyst himself becomes hopeless. 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 for ever, 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 therefore is the unconscious subject of the attack. Freud (1917) suggested that suicide only becomes possible if an individual becomes fully identified with a lost object. Self and object become fused. In phantasy, the attack is upon 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 borderline patient felt that her life's task was to look after her mother. Her analysis had been dominated by her attempts to control her analyst by demanding session changes, phoning out of hours, and seeking sessions at weekends. When her mother 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 if she were dead there would only be a 'slight ripple in the world which would be covered over in an instant'. Her analyst suggested that she felt he 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 because of 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. 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 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 it was agreed, that she should go into hospital. He 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 dictate how he should 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 the attack on the analyst by the patient may lead to severe feelings of *guilt* as the patient recognises his own part in his 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 the patient's past he may become overwhelmed with guilt, believing that he has destroyed those whom he unknowingly loved. The need for punishment becomes so severe as to become a wish to be killed by those whom he has harmed. Suicide becomes the only way of satisfying them. A sense of helplessness may also occur at these times and the patient may feel at the mercy of internal and external events over which he has no control. This further increases the risk of suicide, which becomes an action to relieve the anxiety of helplessness by being in control – to kill before being killed, turning passive into active (Laufer 1987).

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. What is important about the analyst holding the three leitmotifs in mind is to allow him to empathise with the patient's desire to die, to understand the excitement of suicidal phantasies, to recognise the exhilarating sense of power they release, and not to underestimate their destructiveness.

SPECIAL GROUPS

Analysis in adolescence

Many of the problems discussed above are more common in the treatment of seriously disordered adolescents and young adults (cf. 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 men and women of action as they struggle to understand and renegotiate their relationship with the world in the context of their developing social 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 confusion. Internal conflicts tend to be externalised, impulses difficult to control, and feelings dangerous to express. Phantasies can only be partially sublimated. Impulsivity, bewildering sexual feelings, and outbursts of anger and emotion result.

Inevitably these developmental processes affect the analytic process and necessitate technical changes on the part of the analyst, particularly at the beginning of treatment. An adolescent who enters treatment of his own accord usually feels that he has failed in his attempt to rework his psychological world, which was hitherto based on childhood relationships and identifications. He feels a sense of self-loathing and despair. At first it is best to listen and not to interpret. Transference interpretations evoke infantile relationships just when the adolescent is trying to move away from his childhood objects. If transference is addressed too early, the adolescent will be unable to distinguish between past and present objects, and will react as he would to the primary objects he is trying to separate from. As a result, he will have no choice but to terminate analysis.

The analyst needs to help the young person to separate past and present, but first must engage him in an analytic process. Some adolescents, especially those who self-refer, make excellent use of treatment and engage easily, but for others the process of engagement 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 controlled. This is a serious impairment in an adolescent's ability to accept treatment. His 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 leaves before a break, does not attend on Friday, comes for sessions at whim, and may be silent for long periods if the analyst is himself silent. Of course, not all adolescents who come for treatment are so difficult to engage and some may even idealise the analyst, seeing him as omniscient and the cure for all his problems. However, even this has its difficulties. The initial relief at the offer of help leads to an eagerness to talk, which later may turn to wariness of having revealed too much.

Before beginning analysis with an adolescent, it may be necessary to initiate contact with his parents. This is done for two very practical reasons. First, in contrast to adults, whose parental figures are active primarily in the internal world, adolescents continue to deal directly with parents who exert influence externally as well as internally. Arguments, fights, rejection, collusion, over-involvement and excessive protection are but a few examples of what may occur. Second, analysis of patients in early adolescence can only occur with parental support. Only the parents can back up the stability of the setting, and ensure that treatment is neither interrupted by holidays nor prematurely terminated. Often they will be paying for the treatment. They may also be of help during the frequent demands to stop the analysis. Therapeutic support for the family may also be necessary.

Once analysis has begun, the analyst should not fall into the trap

of trying to reassure his patient that he is different from his patient's parents. It is inevitable that an adolescent will imagine that the analyst shares the same beliefs, and will respond to him in the same way, as his parents. The analyst needs to point this out rather than try to show it is not the case. He will come under constant pressure to collude with the denial of problems as the patient tries to repress his feelings of shame and guilt about wanting to be cared for and helped. If his patient has tried to kill himself, the suicidal act will be minimised in importance. It is terrifying for the adolescent to realise that his actions are a result of his 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 his impulses without acting on them, and (d) to recognise that his struggle for autonomy is hindered as much by internal conflicts as by external objects.

Psychoanalysis with older patients

There is no clear definition of the age at which someone becomes an 'older' patient. Freud (1898, 1904) suggested that patients over 50 years of age were not suitable for analytic treatment. He was concerned about the vast amount of psychological material to be covered and the inflexibility of the mental processes after that age. This view has been increasingly questioned and age is no longer a bar to psychoanalytic treatment (Sandler 1978; Nemiroff and Colarusso 1985). The question is not how old someone is, but whether that person is suitable for analysis. In this way 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, to form meaningful relationships and to remain active, is likely to show the psychological flexibility needed for analysis. Older patients who are reconciled to their achievements, show a wisdom borne of their experiences and have stable values, are thought to have a good prognosis (Simburg 1985). Some elderly patients have had psychotherapeutic treatment in the past, although it may have been of limited success; others require treatment in old age due to unconscious fears of death (Segal 1958). Another motivating factor behind a request for help is the 'last chance syndrome' (Hildebrand 1995; King 1980).

For the elderly, death is no longer a general concept but a personal matter as they face the crisis of 'integrity versus despair' (Erikson 1968). Death has its own private meaning to each individual, but Jaques (1965) suggests that unconsciously the phantasy is one of immobilisation, helplessness and fragmentation of the self while maintaining the ability to experience the resulting torment and persecution. Along with this, there is a continual requirement for the elderly to face up to changes inflicted as a result of the ageing process. These may involve a decline in physical abilities, loss of relationships, the need to replace sources of self-esteem, and the acceptance of increasing dependency. Facing these issues is painful, not only for the patient but also for the analyst who may be much younger. To face one's own death is hard enough but to do so time after time within the intimacy of an analytic relationship may be too much to bear (Kastenbaum 1964).

Similar problems occur in the analytic treatment of other patients who are faced with death, such as those with AIDS (Grosz 1993). Kastenbaum also suggests that the cultural outlook on the elderly is bleak and is reflected in the tendency to devalue those who work with them, especially within the psychiatric services. Analysts are not immune from such influences which may interfere with appropriate assessment and treatment. It is important to be aware of other countertransference responses in the treatment of the elderly, especially for young analysts. Unresolved rescue phantasies or hostile feelings related to the analyst's parents may be enacted with the patient (Myers 1984, 1986), fears of intense dependency interfere with the therapeutic process (Martindale 1989) and terror of loneliness leads to a denial of need, including extra-analytic help, on the part of both patient and analyst (Cohen 1982; Treliving 1988).

The patient on psychotropic medication

The undesirable polarisation of psychoanalysis and pharmacotherapy may be responsible for the limited discussion in the literature of the use of drugs during psychoanalytic treatment. It is commonly believed that drugs make people inaccessible to psychoanalytic treatment by dampening down the feelings that are the basis of analytic work. This is not the case. There is considerable evidence of the benefit of combined therapy in many illnesses. A combination of anti-depressants and psychotherapeutic treatment results in a better outcome in social functioning and symptom amelioration than either treatment alone (Klerman 1986). Medication may enable a

patient to participate in and benefit from treatment. Anna Freud arranged for a colleague to prescribe medication for a severely depressed analytic patient, with highly beneficial results in the analysis (Lipton 1983).

Loeb and Loeb (1987) and Jackson (1993) discuss the necessity for medication and hospital care in the psychoanalytic treatment of manic-depressive disorders. 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. A similar process has been observed in the treatment of schizophrenia (Robbins 1992). Wylie and Wylie (1987) show how a severely depressed patient was unable to work within the transference until the use of anti-depressants reduced her affective vulnerability and lessened her terror of addressing underlying conflict.

Psychoanalysis and pharmacotherapy are not intrinsically competitive or antagonistic treatments. Each has a different aim and is effective over a different time scale. This has led to the suggestion of a two-stage treatment strategy in which medication alleviates symptoms and sets the stage for later analytic treatment (Karasu 1982). As psychoanalysts take on more seriously ill patients, this is becoming more common. Patients can begin analysis while they are already taking medication, as well as requiring it during 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. 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 with the intention of stopping it, believing that the analyst was 'anti' drugs. Exploration of this fantasy indicated that analysis was idealised as good treatment, medication as bad. The patient even told her psychiatrist that her analyst had advised cutting down medication. In fact the analyst felt any reduction of medication was part of a denial of her psychotic illness and she needed to acknowledge her need of medication. Only regular discussion between the analyst and the psychiatrist about medication prevented an enactment of the patient's polarised views.

Example: a denigrating drug

A borderline patient 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. At a time of incessant criticism she demanded medication following a series of reports about a new anti-depressant described as a 'wonder-drug'. The analyst felt helpless in the face of her onslaught and was unable to address the issue. He was relieved when she visited a private psychiatrist who prescribed it for her. She brought the tablets to the next session, announcing that she was going to take the first dose of her 'cure'. Taunting him, 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. She could only get close to her object in this sado-masochistic way. Taking a pill had allowed her to feel that *she* could decide when someone 'got inside her'. Gradually the patient's contempt became available for exploration and she stopped the anti-depressant which had, in reality, made little difference to her symptoms.

It is important to ensure that the meaning of medication is analysed in the transference in the same way as any other action by the analyst such as taking a holiday, increasing fees, giving bills or arriving late. Does the medication have a specific meaning to the patient? Does it evoke any particular feelings, especially about the analyst?

Example: an open verdict

A patient who had been in analysis for two years became severely depressed. She had never seen a psychiatrist in the past; and 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 anti-depressant. 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 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.

Gender

Gender is an increasingly important issue in psychoanalysis. Despite Freud's (1931) recognition that the sex of the analyst in relation to the patient may inhibit or influence certain pre-oedipal and oedipal processes, he paid little attention to gender as a topic. Indeed, many of his generalisations and assumptions about sex and gender have been seriously questioned (Grossman and Kaplan 1989). Chasseguet-Smirgel (1984) argues that analysts bring to their work a balance of masculine and feminine traits, 'paternal legislative power and maternal aptitude' respectively, formed through their own maternal and paternal identifications, and that these form the basis of psychic bisexuality. The influence of actual gender on the analytic relationship is thereby lessened, although Chasseguet-Smirgel distinguishes such identifications from a more deeply rooted masculinity and femininity. Thus a woman has a profound and unbroken identification with her mother as a nurturer and container, prototypically made complete through her own pregnancy. On the other hand, the man has to disidentify with his mother, with separation taking precedence over connection, distinction over similarity, and has to ally himself with father. This cuts the boy off from the emotional attunement, sharing of states of mind, and capacity to perceive the other's needs and feelings, that was part of the primary bond between him and his mother. Emotional closeness can now be experienced as dangerous and enveloping, potentially giving rise to the 'core complex' that is found in adult perversions (Glasser 1979, 1986), if not reintegrated. This has led to the suggestion that, although male and female identifications may be present in both men and women, the female analyst is more likely to draw out nurturing maternal transferences from both male and female patients, which develop into dependent wishes of merging (Lester 1990). The female patient accepts and learns from the experience but the male patient reacts strongly as such wishes threaten his masculine identity (Stoller 1985). Similarly, the male analyst may react countertransferentially to powerful symbiotic wishes from a female patient by distancing himself, or, by misinterpreting them as erotic strivings rather than recognising them as a need for maternal care.

Gender-related oedipal transferences are easier to identify as, at this stage, sexual and aggressive urges are directed primarily towards one or the other parent. Generally speaking, powerful erotic strivings are most commonly described in the male analyst–female patient dyad and are strikingly absent from the literature on female analyst–male patient dyads. Not surprisingly the male analyst–male patient dyad is often described as being dominated by aggressive competition with the oedipal father, while erotic heterosexual wishes are directed towards people outside the analysis. Homosexual wishes are inevitably present and may form a resistance in both patient and analyst. Bernstein (1991) sees an equal level of danger in the female

analyst–female patient mix. For the analyst there may be a defence against homosexuality, an over-identification with the patient's strivings for independence, career success and complaints against men, a difficulty in experiencing herself as a penetrating person, and a tendency to regress to the original mother–child relationship. Only if the analyst can extricate herself from regressive and sexual aspects of her relationship with her own mother can a successful analysis take place.

Ethnicity

Psychoanalysis, despite its origins among an oppressed ethnic minority, has never fully addressed the place of ethnic issues within treatment, perhaps because the vast majority of analysts and their patients are caucasian. It has been said that ethnic differences have a negative effect on the process and outcome of psychoanalysis (Bradshaw 1978, 1982), that they distort countertransference feelings (Sager *et al.* 1972), that they serve as a defence from underlying conflicts (Evans 1985) and that they induce analyst-guilt, leaving a white analyst with a black patient unable to maintain an analytic stance (D. Holmes 1992). The internal world may be distanced, with both patient and analyst becoming identified with the down-trodden (Goldberg *et al.* 1974). Underlying problems of aggression, internal conflicts and affective responses may not be adequately tackled but, rather, explained according to social attitude to race.

However, recent research reveals more positive aspects. Studies of outcome of therapy with cross-race and same-race therapist–patient dyads show similar outcomes, although notable differences in process (Jones 1978). Racial difference is a useful avenue for transference reactions and a facilitator of analytic treatment. D. Holmes (1992) shows how racial issues in both same-race dyads and cross-race dyads are powerful landscapes on which to project all that is unacceptable. The danger is that the analyst will accept the prejudice without looking at more psychological causes of conflict. For many patients the use of racial issues may be a potent source of expression and elaboration of defences, object relations and impulses. What is important is that the ethnicity is tackled, and not ignored as if it were a non-issue. Perhaps the clearest clinical instances of the interaction between psychoanalysis and ethnicity are to be found around questions of identity and identification, and

where oedipal feelings of rivalry and exclusion are intertwined with themes of race.

Example: identity confusion

A young woman entered analysis following an episode of severe depression in which she had heard voices accusing her of being a 'racist'. She was the offspring of a mother of Indian origin and a French father, and had been adopted soon after birth into a liberal middle-class family who already had two children. Her father, who had come from an impoverished working-class background and had a strong social conscience, had particularly wanted to adopt a 'black baby'. Her adolescence had been stormy, and, unlike her two academically successful older sisters, she had left school early and had lived a somewhat rackety life. Her depression coincided with her splitting up with a working-class black boyfriend who had told her she didn't fit in with 'his sort of people'. She felt neither fish nor fowl, but returned to live with her parents, while feeling convinced that they did not really want her. Initially she was superficially friendly and collaborative in treatment, but she arrived for a session one day in a state of fury and accused the analyst of being in conspiracy with her parents, of patronisingly seeing her as inferior, of having no idea what it was like to be black in a racist society, and of taking her into treatment 'just to salve your grimy little conscience'. The analyst acknowledged that there might be some truth in these accusations, but on further discussion it emerged that she deeply resented the fact that her parents had pushed her into treatment and that the bills were sent to them, even though this had been agreed at the start. As the transferential implications of all this were unravelled, she grasped how her anger towards the analyst paralleled the anger, and later compassion, she felt towards her natural mother for having abandoned her. She then began to see how her risk-taking behaviour had been a challenge to see if her parents really cared about her, expressing her wish for a more loving relationship with her mother, and to see herself as 'special' rather than second-best. A discussion with one of her sisters revealed that she also felt that their parents were much more interested in themselves and each other than in their offspring. Paradoxically, following this, the patient could begin to allow herself to think of her parents as a loving couple, and the split between the angry 'black' and the compliant 'white' side of her became less pronounced.

MONEY

Ever since Freud 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. Recently, perhaps as a result of social and economic changes, greater interest has been taken in the influence of payment on treatment (Thoma and Kachele 1987; Nobel 1989). In countries with high inflation or where payment is fixed by insurance companies or government schemes, as in Germany and Holland, fees are part of an external reality shared by analyst and patient alike. 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 a slippery slope of payment by relatives, insurance or government, to questionable free treatment even though it is funded indirectly through taxation. Personal sacrifice is felt to be necessary to sustain motivation, to mobilise self-determination, to reduce gratification of narcissistic wishes, and to keep the patient in touch with reality. Even training institutes insist that a patient makes a contribution to treatment, dependent on earnings, to bring in a sense of reality. However, direct payment between a self-sacrificing patient and a better-off analyst must also result in palpable transference–countertransference problems involving resentment, envy and hostility. Eissler (1974) found few problems in payment by relatives, but certainly it may sometimes cause difficulties (see 'an involved husband' on p. 191).

Whatever the source of finance, money has a significant part to play in all analyses. Each source brings its own advantages and disadvantages, opens up channels for phantasies, fears, enactments

and defences. In patients who are in free or heavily subsidised treatment, special attention needs to be paid to underlying wishes to be a favoured patient, and fears of expressing hostile feelings. In the case of third party payment, patient and analyst need to be careful not to collude in minimising the importance of payment or ignoring it completely. Direct payment may give rise to transferences involving control, power, envy, dominance, avoidance of dependence and self-sacrificing masochism. Influences on the analyst may be equally significant. He relies on his patients for his living and may hold onto wealthy patients while feeling less concerned about those paying less, resent the patient who is heavily subsidised feeling he has it too easy, keep patient's in treatment for too long, and slant recommendations for treatment according to vacancies. T. 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 one and 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 low 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 too high as to result in greed or excessive reliance on one patient for income. The ethics of psychonalysis and its role within a National Health Service are important areas of concern (Holmes and Mitcheson 1995). Most analysts would agree with Freud (1919) that 'the poor man should have just as much right to assistance for his mind' as the well-off. How this can be achieved is a topic requiring urgent debate.