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Some therapeutic and anti-therapeutic factors in the functioning of the analyst

As the analyst's capacity to function is mainly expressed by his ability to convey understanding through the way he gives interpretations and what he selects for interpretation, one may say that the patient's feeling of being accepted and cared for depends to a large extent on the interpretative function of the analyst. Like others, I have found that patients respond to our interpretations not only as tools which make them aware of the meaning of the unconscious and conscious processes, but also as reflections of the analyst's state of mind (Segal 1962a, Loewald 1970, Langs 1976, Sandler 1976) – particularly his capacity to retain quietness and peacefulness and to focus on the central aspects of the patient's conscious and unconscious preoccupations and anxieties. The patient is also aware of the analyst's mind and memory through the way he holds together important external and internal factors and brings them together at the right time. The analyst's state of mind, his capacity to function well, is an essential therapeutic factor in analytic therapy. It plays an important part in the introjective processes, increasing the patient's capacity for object relations and strengthening his ego in its functions and in its capacity for integration and particularly for mental growth.

I indicated in Chapter 1 my belief that the principal therapeutic function of a psychoanalyst is to help the patient put into words and conscious thoughts the unconscious feelings and wishful phantasies which preoccupy him. In this way the patient's repetitions of early object relations and the omnipotent defences built up in the infantile period can be modified. Gradually, the patient can tolerate more feelings (and particularly the anxiety they provoke), recognize conflicts, and become able to think about them. As this becomes

more possible the need for the gross distortion of inner and outer functioning which occurs in narcissistic omnipotent object relations is reduced. As I have said, the primary means by which the analyst achieves these aims is by precise verbal interpretation of the patient's phantasies of the transference relationship, focusing on the most pressing unconscious anxiety experienced by the patient at any time.

A corner-stone of my view about therapeutic change is my belief that even the most disturbed and tricky patients, whose pathology may cause them time and time again to defend themselves against anxiety by distorting and undermining the analytic process, not only seek to communicate their predicament but also have a considerable capacity for co-operating with the therapeutic endeavour, if the analyst can recognize it.

Some patients have a vivid and lively capacity to bring relevant material into analysis, through both their verbal and non-verbal communications. I have noticed in supervisions, for example, that if what a patient says is not understood by the analyst it will frequently be repeated two, three, or even four times in a session, in many different ways. Such attempts to communicate (even in the unfavourable circumstances in which an analyst has difficulty understanding the patient) are remarkable. Such patients seem to try to make the material more and more easy to understand with very little resentment about the failure of the analyst. They are particularly likely to communicate what they feel and think about the analyst, and, as others have noticed, their understanding of the analyst's problems is often vivid and precise (Searles 1965 and 1975, Langs 1976). I have observed psychotic patients with this capacity, not only neurotic ones. They seem to have much tolerance for the analyst's weakness and to have a great capacity to live and to look for object relations. Other patients, particularly schizoid ones, of course, are much more easily discouraged and quickly withdraw when they feel snubbed or not understood. Even so, I have noticed that psychotically regressed patients belonging to this group often have an amazing capacity for communicating their needs and observations, particularly by non-verbal means – although when non-verbal means predominate I do not mean to imply that the patient is silent and unable to use words. It is rather that their language sometimes sounds as if they are in a dream. Such language is common with schizophrenic patients and it takes some time to learn. It exemplifies my contention that careful consideration of even the most disturbed psychotic behaviour can be rewarded by finding that it communicates something meaningful.

Analytic material from several of my patients indicates that from

very early on infants not only relate to the breast and the way the mother handles the feeding situation but also seem to be acutely aware of some aspects of the mental state of the mother as a whole person and of her capacity, or incapacity, to feel related to the infant. Such patients can sometimes be openly critical of the analyst's failure in understanding. If the analyst misinterprets such criticisms as sadistic attacks, then the patients often have great guilty feelings about their capacity to understand the situation better than the analyst himself. This guilt increases if they realize that the analyst seems unable to bear their correct observations. If the analyst continues to ignore the patients' criticism and insists on interpreting their observations as attacks on him, they feel they are being made stupid and infantilized. Some of these patients are at times capable of misusing their capacities and becoming omnipotent, destructive, and triumphant. They then have difficulty differentiating between their capacity for critical perception and such aggressive feelings as envy derived from infantile dependence; their helplessness is revived in the analytic situation. Probably this confusion developed during the traumatic experience of the infant–mother relationship, creating in these patients a sense of guilt which forces them to destroy their unusually sensitive capacities to function and to present themselves in analysis as severely disturbed in their mental functioning. Nevertheless, I have found that such patients, even if they are clinically psychotic or borderline, have a good prognosis if they are carefully and sensitively handled by the analyst.

Anti-therapeutic factors in the analyst

To function carefully and sensitively, and so to be therapeutic, an analyst depends to a crucial extent on the functioning of his personality as an important instrument or tool. For that reason we are trained not only clinically and theoretically through lectures and supervision, but also through personal analysis. As I mentioned in Chapter 1, in his analysis the candidate's character structure and character disturbance, his known and unknown problems, have to be located, gradually brought into the open, and integrated into his personality to help him withstand the wear and tear of analytic work and to be receptive to a multitude of patient problems, including psychotic and borderline problems. The analysis of the analyst's defensive structure must include his defences against deep-seated early infantile anxieties, which often hide unconscious psychotic anxieties or problems. Although our training forces us to be more sane, it must temporarily make us more disturbed and anxious in

order to gain the knowledge and experience about ourselves necessary for us to function. I think we all realize that some of our problems remain unsolved and that we must strive to develop, and to remain in contact with, ourselves. We serve our patients best if we are honest with ourselves and thus open to accept fully what the patient is. Unless we help our patients to realize fully who they are, no real change in their personality can take place.

We must also accept that each analyst is different and works differently with his patients, but this does not mean that we should deny our own or our colleagues' shortcomings or achievements. Discrimination, a capacity for criticism, is one of the most important ego functions that we need in our work. Klauber (1972) had the courage to describe details of the analyst's pathology and how this interferes with his therapeutic role. His aim was to draw attention to the great difficulties in doing analytic work, although he was rather uncertain about them. I fully agree with him about how difficult it is to face up to the truth about ourselves and to maintain our concern with this problem. However, I think that more can be done about the problem than he envisaged by spelling out and making conscious the way an analyst can be anti-therapeutic. In this respect there are three issues which have particularly preoccupied me. They are the tendency of analysts to adopt particular directive roles towards their patients, the tendency to offer badly timed and vague interpretations, and the tendency too rigidly and restrictively to pursue a particular line of interpretation. Some of these tendencies arise from theoretical controversies and confusions about the nature of the analyst's therapeutic role but they are also compounded by unrecognized unconscious demands from the transference relationship with which the analyst can all too easily collude.

The analyst's attitude and role

In trying to clarify the role and attitude of the analyst towards his patient two views have tended to be advanced. On the one hand there is Freud's (1916–17) dictum that we should regard analysis simply as an investigation and should not approach it with any therapeutic expectancy or desire. This view was at least partly supported by Bion (1970) when he spoke of the need for the analyst to approach his patient without desire. On the other hand several analysts have pointed out that the attitude often adopted towards the patient is frequently a motherly one (Money-Kyrle 1956, Gitelson 1962, Langs 1976, Sandler 1976). Bion's (1962a) recommendation

about the attitude of reverie and Winnicott's (1956) primary maternal preoccupation are also related to the role which a mother intuitively takes up towards her infant.

I have always felt that both the surgical approach described by Freud and the preoccupation with the analyst as substitute mother are inappropriate. There is a danger that we become caught up in a particular directive role towards the patient instead of taking care that this is left completely open throughout the analysis. The analyst will be placed via the transference in many roles, not just the role of mother or infant – good, bad, or indifferent. I therefore agree with Pearl King (1962: 225), who, when discussing the Symposium on the Curative Factors in Psychoanalysis in 1961 at the Edinburgh Congress, said that

> 'The attitude that an analyst adopts towards the curative process in psycho-analysis will determine his attitude to his patient, and his handling of the analytical relationship. . . . The relationship of the analyst to the patient is in my view unique. . . . It is not meant to be a parent–child relationship.'

She went on to say that 'I sometimes think of the analytic relationship as a psychological stage on which I as an analyst am committed to take whatever role my patient may unconsciously assign to me.' She makes it clear that it is not her wish to play exactly any original role but to make the patient aware of the role he is making her inhabit. I am in full agreement with this formulation. By contrast, if the patient successfuly provokes the analyst to take on a certain role, to act out, it will bring the therapeutic function of analysis to an impasse.

If I am doubtful about assuming any fixed role I am also dubious about an attitude of detachment. It seems to me impossible to destroy our desire and intention without severely damaging the relationship with our patient. When we accept a patient for analysis, or a candidate for training, we are in fact expected to concern ourselves with that particular patient very thoroughly, and we intend to try to understand and to help him. However, it is essential that we thoroughly analyse our attitudes and intentions. The desire or expectancy which interferes in analysis and which is felt to be disturbing by our patients is our narcissistic desire to do well with or to have a patient who gives us satisfaction in our work and so indirectly increases our satisfaction with our therapeutic capacities. We all know that even normal satisfaction with our patient's improvement is often very suspect to that patient and is an important factor in negative therapeutic reactions. Although it is sometimes

extremely difficult to differentiate between the patient's projections and true perception of the remnants of the analyst's narcissistic attitude, we do know that these narcissistic needs make the analyst liable to act out with the patient and become personally involved. This experience creates a feeling in the patient, not of being accepted or cared for, but of being seduced by the analyst, and on a deeper level it creates a feeling of loneliness and rejection or of being misunderstood. It leads to impasse or worse.

The analyst's intentions exert a particular danger, I believe, in those situations where the nature of the patient's psychopathology is particularly likely to create strain in the counter-transference. Severely traumatized patients, who are often driven to repeat past traumatic situations in the analytic situation, are particularly likely to draw the analyst into unconscious collusion with them. They insist that the analyst must know exactly what conscious and unconscious terrors they have suffered in the past, projecting these experiences violently into him. These situations are, of course, extremely painful for the analyst. If they are unbearable to him, the analyst may collude with certain idealized patient phantasies by creating 'corrective therapeutic experiences', rationalizing these as assisting the patient in the search for a much better environment or a more comforting object than he had in the past. Such efforts destroy the analytic process and the process of trying to verbalize what is happening and to help the patient to face it.

In my experience a misunderstanding of the reason why the traumatized patient feels so compelled to repeat his past experiences goes along with the enormous transference demand felt by the analyst. As I see it, one of the most important facts which has to be considered about the traumatic experience is that the patient has had to cope all on his own, sometimes for a considerable time. Often he has survived only through such severe defensive reactions as denial, splitting, and depersonalization. Thus, when the patient dares to turn to an analyst for help, he expects him to share the terrifying experiences which are quite unbearable for him. Unconsciously he often tries to involve the analyst in his experiences by very forceful projections, sometimes so violent that they appear to be attacks on the analyst and his work. This is a painful and difficult situation for any analyst to bear, and, if he does not err on the side of providing corrective experience, a second anti-therapeutic response to which the analyst can so easily resort is to interpret the projections as sadistic attacks on his noble efforts to help. In this case the patient also feels rejected and withdraws. He fears that the analyst wants to retreat and cannot stand being involved with him. In consequence

the violent projections can increase and make the situation all the worse. Only if the analyst succeeds in the difficult task of interpreting the patient's anxieties correctly, as well as pointing out his need to share his experiences with the analyst by making the analyst experience them, can the violence of the patient's projections gradually diminish.[1]

Vague or badly timed interpretations

A second way in which an analyst can very easily be anti-therapeutic is if his interpretations are not sufficiently precisely orientated towards the patient's immediate anxieties or are badly timed. Sometimes an analyst will be aware that there is something about himself that is worrying the patient but be unable to interpret accurately enough about it.

Many patients react very strongly to the analyst's timing of interpretations – for example, to prolonged silence or to his interpreting too quickly. The patient may feel left alone too long, or may feel criticized or rejected by the analyst's silence. If some problems are not taken up by the analyst, the patient may react as if the analyst does not want to know about these problems because they are unacceptable. Consequently the patient will feel that he must keep these problems to himself. The analyst's capacity to respond with sensitive timing of his interpretations, and through assisting the patient to face those areas of his mind which are unacceptable to him, has an important therapeutic function. However, if we interpret material too precipitately before it is possible to know the full significance of the patient's communication, the patient may suspect we are too anxious. The patient will realize that we are uncertain and afraid that we may not know and understand. This will not just be felt as a rejection; it can also be perceived as an omnipotent defence, on the part of the analyst, against experiencing anxiety or uncertainty with which the patient may feel he has to collude (Langs 1976). There are many patients who are afraid to get into full contact with their deepest anxieties, so instead of feeling and knowing who and what they are, they pretend to know. If the analyst joins with them in this activity, the therapeutic function of analysis comes to a halt.

Other patients, however, like those mentioned a little earlier, will often do a very great deal to try to communicate to the analyst an anxiety such as that the analyst is frightened of them or the kind of

feeling they experience. One analytic session I have encountered illustrates this phenomenon particularly clearly.

At the beginning of the session, which took place on a Wednesday, the patient, Sylvia, seemed to the analyst to talk about a mental state of remoteness, indefiniteness, and timelessness which worried her. The analyst related Sylvia's state to the weekend, when the analyst had of course not seen her. To this Sylvia responded by saying, 'It is important for people I am with', explaining that she functioned 'on the level of feeling'. The analyst told me that she had difficulty understanding what this might mean but commented to Sylvia that she thought she might be talking about how influenced she is by her ideas about what other people are feeling. Sylvia replied that she agreed, she must be very careful when other people get flustered. At this point her analyst made a third comment suggesting that Sylvia was frightened of being left alone. This time Sylvia replied by talking about how she had rung the bell at the beginning of the session but had to wait for the analyst to use the buzzer to let her in. This comment confused the analyst, but subsequently Sylvia repeated how she felt unreal, stating that, as she was waiting at the door, she had tried to look at the analyst's name-tag under the bell. This time the analyst interpreted that the patient was trying to express how much she needed evidence that the analyst existed. The analyst emphasized that she was actually there with the patient at that moment. The patient responded to this communication with silence. Later she talked about a car that had cut right across in front of her, but was reluctant to say any more.

This interchange between Sylvia and her analyst will be described and discussed in much greater detail in Chapter 3. I quote it now to illustrate how patients try very hard to communicate with their analysts and how in the absence of an accurate understanding they can get more and more confused, leading to an impasse in the therapeutic relationship. I suggest that on various occasions during the session Sylvia tried to indicate to her analyst that something was going wrong. The problem which developed in the session and became more and more frightening was her feeling that her analyst did not understand her, could not cope with her feelings, and therefore absented herself not just at the prearranged weekends but more crucially in the sessions themselves. First, Sylvia responded to the weekend interpretation by gently correcting the analyst – saying the problem was not at the weekend but now, with 'the people I am with'. When this is not understood she begins to be frightened because she fears that her analyst is 'flustered' by her. Next, growing more worried, she employed strong symbolic language to suggest

that she felt the analyst was out of touch with her, that she didn't ring a bell in the analyst's mind. Then, worried by the time it is taking for the bell to work in the analyst, she repeats how she feels unreal and implies she is getting confused about where she is and who she is talking to, referring to the name-tag. Finally, exasperated in her own way, she still tries to communicate about what is happening by talking about how the analyst (car) is dangerously cutting her up. The remarkable thing about this interchange, understood from this point of view, is how tenaciously the patient keeps trying to communicate her ideas about what is happening with her analyst. Instead of being able to help her understand her anxiety and to explore the basis of it (no doubt in her infantile sadistic and omnipotent wishes), the analyst misses the chance to be therapeutic, grows more and more anxious herself, and actually contributes to the patient's anxieties about how dangerous she is. A patient who is able to communicate forcibly needs desperately an analyst who is receptive to her communication, and there is a great danger that the patient will deteriorate if she cannot find this particularly close contact and understanding which psychotic patients depend on.

I shall not explore the disturbed interaction between Sylvia and her analyst any further here, as the case is discussed in detail in Chapter 3.

Rigidity and inflexibility

Areas in which the analyst functions badly and which lead him rather too rigidly and inflexibly to pursue a line of interpretation without noting its harmful effects (as in the example just given) may be the result of only temporary blockages activated by internal or external conflicts. If these problems interfere with the analysis for only a short length of time, the therapeutic co-operation of the patient will generally return. However, if the analyst has many areas which can be described as 'private: no entry' – as Heimann (1975) has recently so perceptively described them – then the analyst and patient may collude unconsciously to keep those areas out of the analysis and so create a therapeutic impasse. The patient may criticize the analyst quite violently in many different ways, but nevertheless avoid the area and the situation where the traumatic experience of feeling rejected by the analyst's behaviour occurs. The attacks of such a patient are often misinterpreted by the analyst, who may try to relate this behaviour to past experiences. This may lead to acute anxiety and increased critical or contemptuous attacks on the analyst,

augmenting feelings of hopelessness in the patient because it nourishes his fears that it will be forever impossible for him to be understood and accepted. If the analyst is able to diagnose the patient's behaviour and recognize his own mistakes along with the detailed causes of the failure, the patient can generally bring his observations to the notice of the analyst. When in fact the analyst is able to take the observations of the patient seriously and is able to succeed in verifying both in himself and in the patient the various areas of blocking, the impasse in the analysis will clear.

The most common blockages in the patient–analyst interaction relate to the analyst's unconscious, infantile anxieties. One defensive manoeuvre through which the analyst deals with his anxieties is to collude excessively with one aspect of the patient's personality in order to keep other unwelcome problems out of the analysis. If the analyst is open and receptive to the patient's early infantile anxieties, the patient is generally aware of this, and if these anxieties are urgent, he will be able to follow his need to project his anxieties into the analyst for communication, help, and understanding. It is generally only when the analyst is defensive and disturbed by the violence of the patient's reactions that arguments and battles between patient and analyst occur. There is then the danger that long-lasting psychotic transference manifestations may become fixed.

Battles and long-lasting psychotic transference reactions can often be shortened if the analyst understands the most prominent immediate anxiety. In these states the predominant patient anxiety is often the fear that he will drive the analyst mad or that the analyst will drive him mad (Searles 1959a). One can readily understand that in such situations the patient becomes acutely panicky and defensive. It is very reassuring for the patient if the analyst can succeed both in functioning well in his interpretative role and in retaining his quiet, thoughtful state of mind.

I think in all cases of impasse or deadlock in analysis it is essential, first of all, for the analyst to examine very carefully his own feelings and behaviour towards the patient. It is equally important to scrutinize carefully the patient's communications and dreams both for any information that may throw some light on the picture of the analyst which the patient has incorporated and for any hint about collusion between analyst and patient. It is only by the analyst's recognition of his own mistakes and a change in his emotional orientation towards his patient that the patient is allowed to feel freer. It is then that the patient is released from the collusive trap. The impasse can then be lifted fairly quickly.

An analyst stuck in a collusive counter-transference may need

some discussion with an uninvolved colleague; such an observer often has a chance to diagnose the problem much more easily. An example of the way an uninvolved observer can help comes from the work of a female analyst, Dr T., who some years ago consulted me about an eighteen-year-old female patient, Lucy. She reported that she was concerned about the discrepancy between Lucy's frequent emphasis that she needed a great deal of help and her simultaneous appearance of being unresponsive and dead, unable to take in more than the minimum of interpretation. It seemed that after any interpretation she became silent, and she generally gave only a few associations to dreams. Dr T. felt very dissatisfied with the progress of the analysis and believed that it had reached an impasse.

Dr T. reported a session after a weekend. Lucy said she had had a very upsetting dream. In the dream she was in a car, her boyfriend was driving, and she sat beside him; on the back seat were two friends – a couple. It was night, and they drove through fields. There were cherry trees full of ripe cherries near the road, and she picked some of them. They soon came to the farm to which the field belonged, and there was a girl of ten. They stopped, and the girl said, 'You should not take the cherries.' 'To taste only,' said Lucy. 'Not even to taste,' answered the girl. Lucy ran to the car, and they drove away. The girl shouted for help, and several people pursued the car. In the end, Lucy found herself in a big country house where she and her boyfriend were caught. A woman dressed in black said prayers as if Lucy were condemned to death. She and her boyfriend were brought to a church, where again there was some kind of ceremony of punishment. This time there were high priests with their mitres.

In a second dream Lucy knew that she had died in a car accident. She rushed home to tell her mother that she was still alive and that she should not worry. At home she found that people were crying, and her corpse lay in state. The people suggested dressing the corpse, and Lucy said she could give some dresses to it. She associated that there had been talk over the weekend of breaking off the relationship with her boyfriend because it had no future. She also discussed a meeting with other friends.

She then reported a third dream. In this dream she was with a man with whom she had more communication than with her boyfriend. She would have liked to be amorous with him but thought she did not know how to go on with it. She was probably 'too little expressive'. There were no associations to this dream. Dr T. interpreted in some detail that she felt that Lucy was secretly stealing from the analysis and using this for other relationships. This was

causing here severe guilt and feelings of persecution, making contact with Dr T. impossible.

In listening to the presentation of the material I was impressed that Dr T. had given interpretations which had an accusing and guilt-provoking character. She had not really used the three dreams, although they were vivid and lively as well as revealing. There seemed at that time some collusive relationship going on between patient and analyst which was creating a picture of Dr T. as a woman in black, making funeral speeches. Lucy colluded with this, as in the dream she contributed material – the dress – to the corpse. However, the condemning attitude of Dr T. was reinforced by her not taking up the information tht Lucy had visited the mother – standing for Dr T. – to tell her that she should not worry and that Lucy was alive.

In listening to the details of the dream I had the impression that the secret stealing and the desire to taste the cherries referred to secret sexual wishes, as did her associations to the dream in which she felt sexually attracted to a man-friend but unable to express this to him (as in the analysis). In this way the dreams gave evidence of Lucy's difficulties in expressing her secret lesbian desires in the transference – evidence only slightly obscured by making the analyst into a man. The detailed examination of Lucy's history revealed that her mother had not been able to feed her as a baby, and her father had immediately engaged a wet-nurse, a sensuous woman, who fed the child for at least one year. The father had died in a car accident when Lucy was thirteen, and Lucy had dreamt about a car accident. After her father died, it was revealed that he had had a secret love affair with a woman for the past three years. (The age of the girl in the dream, ten, could thus represent the beginning of the father's love affair.) When the mother found out about this, she became severely depressed. The positive feature in the analysis seemed to be the very open revelation of the whole situation through the dream. Even the lack of associations contributed to the better understanding of the dream. However, it seemed that the analyst considerably colluded with Lucy in repeating the behaviour of the left-out and depressed mother when the secret love affair was revealed. Lucy's secrecy about her attraction to Dr T., which repeated her attraction to the breast of the wet-nurse, contributed to the collusive creation of the deadly punishment situation, in identification with the dead father in the transference.

I have chosen this material to clarify an impasse in the analysis caused by a collusive relationship between analyst and patient. I also wanted to illustrate how it is essential during the analysis to be able to observe one's own tendency to make interpretations which sound

accusatory or super-egoish to the patient. Dr T. in this case reported that her discussion with me helped her to understand her critical counter-transference better, and that she was able to feel much better about Lucy. This is, of course, easier when one arrives at a fuller understanding of the patient's history and mental organization. In cases of impasse the detailed examination of analytic material, in order to find possible evidence for a collusive relationship between analyst and patient, seems to be especially important. The re-enactment of the history in the transference impasse is rather common. In this connection it is interesting that Dr T. chose to report the session with the three dreams in which the crucial problems she was having with the patient were so astonishingly clearly highlighted.

Summary

In this chapter I have tried to develop the investigation of transference and counter-transference begun in Chapter 1. The therapeutic function depends on the analyst's openness and sensitivity and his capacity for detailed observation which enables him to follow the patient's material in detail in order to establish the main anxiety at any moment. The analyst has also to know that there is a healthier, sane part in every patient that, if understood, consistently tries to communicate to the therapist the predicament the patient finds himself in.

Briefly to repeat the main points:

1 The analyst will be placed via the transference in many roles by the patient, not just the role of father or mother or good or bad person or infantile parts of the self. The analyst should perceive the changing role which is often indicated by his projection but not act this role out with the patient.
2 Analysts tend at times to get caught up in a certain way of thinking which really implies a not thinking. This leads to interpreting, for example, envy all the time when something else is more pressing. The persistent interpretation of weekend or separation anxiety, when the problem for the patient is the analyst's existence or non-existence in the sessions, is another example.
3 Sometimes analysts will be insensitive to criticism from their patients and in so being will miss significant communications.
4 Sometimes analysts will be blind to the patient's tendency to get them to collude with their ways of thinking and being.

These four points, summarized here, are illustrated at least once in later chapters, beginning with Chapter 3.

Note

1 Freud has said that traumatized patients respond better to treatment than those with constitutionally determined conditions. My own experience confirms Freud's statement. It is, however, inevitable that the severely traumatized patient who has to relive early infantile states in the transference will have to get in touch with severe psychotic anxieties which tend occasionally to get out of control. This may temporarily cause a confusion that is difficult to deal with. In the traumatized, deprived patient, psychotic anxieties often continue to exist in their original form. The early infantile anxieties were often severely exaggerated by the traumatic situation, particularly if it involved early childhood separation lasting for years, starvation, illness, or maltreatment.

3

Breakdown of communication between patient and analyst

In Chapter 2 I briefly drew attention to some of the things which can go wrong to undermine the analyst's therapeutic efforts. In this chapter I want to illustrate some of these difficulties more thoroughly by examining in more detail some of the material about the patient, Sylvia, mentioned in Chapter 2 and presented in one of my seminars. The analyst presenting the case had previous psychiatric hospital experience but had not previously attempted a psychoanalysis of a psychotic patient. She got into considerable difficulties with Sylvia's treatment, and the patient eventually broke it off. In the seminar we came to be aware that this outcome occurred partly because the analyst had not obtained a clear enough assessment of the patient and so had not arranged adequate support for herself and her patient, but also because the analyst was not able to bring the therapeutic factors in the treatment into effect. Specifically she became preoccupied with her own line of thinking and was unable to hear the patient's warnings that she was pursuing a wrong line. To illustrate what I think happened I shall interpose reports about Sylvia's sessions (made by her analyst, Dr M., and printed in italic type) with my own comments printed in roman type.

'In May 1974 Sylvia was twenty-seven and had come five years ago, with her husband and first child, who was then six months old, to England. In the first consultation she told me that one month before Christmas 1973 she mentally collapsed and could not do anything. She suddenly had a feeling that she was never going to see her parents again and there would be no more aeroplanes, so that she felt it was like "dealing with the dead". She first attributed her breakdown to the fuel crisis in England. Only later on did she