30 The Last Lecture

In this last lecture I want to speak about those aspects of psychoanalysis which for me are central. I do not believe that any lecturer can hide his or her own personal attitudes or bias any more than a psychoanalyst can do so from his or her patient. But what I want to do, in this last lecture, is to make explicit what has been implicit. This has a clarifying function for me, and for you; for when my attitudes stand out clearly it gives you a better opportunity to compare your own with mine and to find where you agree and where you disagree.

I have stressed that the psychotic patient will burrow away until he finds out what is in the analyst's heart. What does the analyst really think and feel? This is what will concern him. I have found, for instance, that all the mentally handicapped patients who have been referred to me have wanted to discover whether at heart I really want their existence on this planet or, if honest, would I prefer that they drop off the edge of the world and disappear from my sight for ever. No amount of supervision or technical improvement will alter the situation one bit.

I have said that this is also true of psychotic patients, but I follow Melanie Klein in believing that in all neurotic patients there is an underlay of psychosis, and therefore the analyst's attitude is of importance to the therapeutic outcome in all our

patients. I once had a patient who frequently went into a droning tone of voice that made him inaccessible. For years I could get no understanding of this; then one day I commented that he had passed over, in an aside, his involvement in a series of lectures opposing apartheid. I knew that inside him he felt passionately about the issue, and I said that he wanted to hide it from me, because he was afraid that I would rob him of his passion. I added for good measure, 'In other words, you fear that I will castrate you'.

Then I noticed that he went into his droning tone, and felt convinced that this was connected to my comment about castration. I kicked myself. Why the hell had I not been satisfied with what I had said about robbing him of his passion? Why did I have to go on to make the remark about castration? I think somewhere I was lured into thinking that a good follower of Freud would make sure he spoke about the penis and castration. And after all, surely I wanted to be a good potent analyst? Still kicking myself, I said to him that I had noticed that since my last remark he had gone into his droning voice. He said that when I had added that last phrase about castration he thought I was just dishing out analytic talk, and he just slipped into a tone of futility. Of course what he rightly perceived was that at that moment I had lost interest in him and in making contact with him, and instead was concerned to wave my penis around and say, 'See what a potent analyst am I'.

Each new patient therefore challenges the analyst to further his emotional development. We all flee from emotional contact, especially in those areas where we are not in good emotional contact with ourselves. It is for this reason that I have stressed that the most difficult matter for the analyst is to 'take' a transference. The interpretation of it is relatively easy, but taking a transference has a special difficulty which I shall explain, for the transference is a distorted truth about the analyst.

The analyst is misperceived in some particular way, and very

often this is uncongenial to him. It will be uncongenial only if the analyst has not come to terms with that particular element in his own personality. I gave you the example of the psychotherapist whose patient said she was like Mrs Thatcher, and I can think of another therapist whose patient called him a rigid Freudian. He could not bear it, and yet it is necessary to bear it for the following reason.

When the analyst manages to make contact with the healthy developing side of the personality it will always be the case that the infantile side will rise up against the fertilizing analyst. The infantile side will feel the good intercourse between the analyst and patient to be a threat to its existence, as indeed it is, and it will feel the analyst to be authoritarian, or persecuting, or feeble, or cowardly, or uncaring, or 'just like my mother always was', and so on.

Now there is no doubt that if I look into myself I *am* authoritarian, am persecuting, am feeble, cowardly and uncaring. I am not saying that I am like this all the time, but given certain stimuli then these elements will come out. If I cannot come to terms with my cowardice then I will not be able to take it when my patient calls me a coward. That is the type of transference that I will not be able to bear, and demonstrates the meaning of Harold Searles' statement (1975) that in every transference there is some grain (or more than a grain) of truth.

What I am saying is very closely connected to another truth, summed up in the epithet, 'The analyst cannot make an interpretation when he is too anxious about the topic'. If an analyst is very anxious about sexual feelings which he or she is having with a particular patient, he will have difficulty in interpreting the patient's own sexual feelings towards the analyst. I remember that when I was in charge of a small psychotherapy unit a psychiatrist rang me, with some urgency in his voice, to ask if I could see a patient who had been in a group of his for some time. He mentioned that she had been in another group before that, but neither he nor the other psychiatrist had been

able to get her settled in the group; he felt she would do much better with individual treatment.

I explained the procedure to be followed by those who wanted psychotherapy at the unit. He said to me, 'But she is a special patient. Could you not see her without going through all those formalities?' I told him that she would have to. The patient duly sent in a letter and a form, and I sent her an appointment, but before she came for it, the psychiatrist was on the telephone again, wondering why I had not seen her. The anxiety in him was palpable and I began to wonder what sort of patient would walk through my door next Tuesday at midday.

It was not a surprise when an attractive and vibrantly sexual girl came into my consulting-room. An hour passed during which she told me many things, but with definite reluctance I said to her, 'I wonder how confident you feel about yourself as a sexual woman?' And there poured out of her a great torrent about her intense feelings of inferiority and low self-esteem as a sexual woman. The apparent sexual vibrancy was the False Self, behind which was a frightened girl who was quite unsure of herself.

I said that I put my question to her with reluctance. I could feel the sexual vibes, and it worried me enough to mean that I had to take an inward gulp before I could put my question to her. I came to believe that the problem with the two psychiatrists had been that they had felt aroused sexually, felt anxious or guilty about it, and then found they could not say anything about the most manifest symptom. This is a rather straightforward example of what I mean when I say that the analyst cannot make an interpretation on a topic about which he is too anxious; there are many which come up every week in analytic work which are more subtle than this. It may take a long time before the analyst can overcome his difficulty, if he ever manages to.

Once an analyst has become aware of his envy in a certain respect, for instance, he can see how he is being stimulated and

he has this material available for interpretation; but what is he to do *before* he becomes conscious of it? The answer is of course that he cannot, by definition, do anything about something of which he is not aware. In whom then does the patient (and the analyst too) put his or her trust?

A female patient said to me once, 'How do I know that you do not envy my femininity and so block me subtly?' She could not be certain and I could not be certain. What I was able to interpret, however, was her phantasy that I did know and then later her notion that I had power over the process of knowledge. If I wanted to know then I could know, just by a conscious act of will. It was a disappointment to her when she realized that I, just as much as she did, had to wait for enlightenment. She then became aware that a process was going on in the two of us, and that we could not hurry it faster than it would go. So: there is the patient and the analyst in the consulting-room, but there is also a process. This is the third term in which trust is ultimately placed. The process of analysis is the master of both analyst and patient.

What will help the patient (and the analyst) to develop is emotional understanding. The analyst's job, then, is to make emotional contact with the patient: it is when an analysis is a rich emotional experience for both parties that it enables the patient to grow. Emotional contact, together with understanding, nurtures man's soul and then he can grow and develop to full capacity. Intellectual understanding alone cannot nurture – what the patient requires is intersubjective emotional understanding.

I think I can best illustrate this idea from the psychotherapy of a patient who was mentally handicapped. According to his records he had an IQ of 59. For many months he was in a great state of anxiety, and used to pace up and down and around the consulting-room. I did not feel at ease just sitting down in my normal chair and watching him, so I used to stand and walk around the room as well. He pounded me with questions which

I would not answer, but a stage was reached where he began to ask for my picture of him. How did I think of him? He was frantic to know, and shouted to such an extent that on a couple of occasions people knocked at the door, enquiring whether everything was all right, which it obviously wasn't.

During all this time there were two forms of speech: one the direct speech to me and the other, words that slobbered out of the side of his mouth that I was not supposed to hear. In his frantic way of talking he said in the direct speech,

> Well, if you're not going to give me a picture what are you going to give me?

Then there slobbered out of the side of his mouth these words,

> And thirty-three years? Is that all nothing?

I had often heard this particular slobber before, and in a flash I understood that he felt his whole life to be an empty waste so I said to him,

> You want me to give you a picture and I think it is like this. Imagine that you are sitting in a railway carriage and you find yourself facing a man whose face is torn and bleeding and terrible to look at – this is you with thirty-three years of empty waste. You ask me for a picture because with this you can cover up this awful sight.

And he said,

> Well, if you aren't going to give me a picture then what are you here for?

At that point I came and stood beside him and I held his shoulders and said,

> If you've got me here beside you, looking with you, it just might be possible for you to look at this awful thing.

Then there was a sigh followed by a pregnant silence. Then he

went over to the chair and collaped into it . . .

That is what I mean by emotional contact accompanied by understanding. With this patient that moment led to observable change: he no longer pounded me with questions; he usually sat in the chair opposite me like my other patients; his conversation was 'normal', which it had not been before; and his anxiety quotient dropped dramatically. It is these moments of emotional understanding which heal and facilitate real integration.

I will give you one other example. I was treating a man who hated the long summer break, hated it when I moved house and pressurized me into accepting his view of the world. One day I had a flash of understanding and I said to him,

> You feel me as your baby and you are mother to me and you want to hold me close to you and not let me go. When I go away for the summer break you feel as if I-your-baby have been ripped away from you.

After a long pause he said,

> I get a picture of myself talking to Sarah and pleading with her to stay with me.

I said,

> This is your way of patterning the feeling and understanding it.

He said,

> I have a feeling that Mary's hatred of the analysis has something to do with this.

I said,

> Mary was your baby and you protected her, which she hated, but which she also wanted. When you turned to me and took me as your baby instead she could not bear it.

There was a powerful emotional atmosphere in the room, and it

was released through the image of me as his baby and him as my mother. It was a striking realization for him – but for me also. The emotional experience of being a baby with a possessive mother was extremely uncongenial to me, and I have no doubt that it was this which accounted for the long years it took me to see what I have just recounted.

Closely connected to what I have just said is the idea that the analyst must desire his own emotional development. As I have said several times in this series, patients will challenge the analyst to grow emotionally. If the analyst does not want this, or if he reaches middle age and thinks to himself that he will gently settle down, then analysis is at an end for him. Emotional development does not happen smoothly, but by great upheavals that are extremely disturbing; Bion said that during one of these upheavals you do not know whether you are breaking up or breaking down. However, there is no possibility of being a satisfactory analyst if you do not desire your own emotional development; and patients for whom analysis is the appropriate treatment are those who want a revision of their emotional lives. Psychoanalysis is not for the person who has had a breakdown and just wants to start functioning again, because as the analysis proceeds he may have to revise his whole life and alter it radically. I think that psychoanalysis is for those who have a curiosity about life, but also a wish to live it inwardly.

I believe that the only interpretations which really work are those that proceed from the analyst's ego. There is a very powerful group superego operative within the psychoanalytic community and this forms a mythology; I would like to mention a number of these myths. The first is that the patient knows nothing about his analyst; whereas in fact the patient makes quite an accurate assessment of the analyst at the very first interview. This assessment, it is true, is often covered over with illusory elements which partly make up the transference, but the fact remains that the patient learns a lot about the analyst in that first meeting.

Actually there is no doubt that the patient knows the analyst better than his social acquaintances and even friends do. The patient may know fewer biographical facts about the analyst, but these are not the facts that illuminate a person's character. So if this is the case, then is it really necessary to hide oneself so carefully? To be over-careful about not revealing things about oneself limits the richness of analytic possibility. For psychological realities are extremely difficult to describe and convey, and the analyst needs every bit of personal experience available for use.

I once had a patient who was very frightened of violent emotion, but the reason for it was that she did not feel held. At home we used to have one of those rather noisy coffee grinders, and if we put it on and our two-year-old boy was in the kitchen he burst into tears, but if either my wife or I picked him up and held him while the infernal machine was doing its worst he felt all right and did not cry. This was the best analogy I could think of to explain my patient's fear. She could bear violent emotion when she was being held but not when she was not, so I told her about my son and how she was similar in this way.

Similarly, I once wanted to speak about a primitive form of communication with a patient, and the only way I could describe it was to tell him of an incident that George Orwell relates in *Homage to Catalonia*. If I had held back because I thought I should not let him know that I had read this book, then I would not have been able to put into words what I wanted to express. I believe the communication would have been impoverished thereby. Transference is such a powerful emotional phenomenon that I do not think some acknowledgement of personal attitudes interferes with its operation.

It is an ideal within analysis that the patient should tell the analyst everything, but this goal is never fully attained. Every patient keeps his secrets, and even consciously does not reveal everything to his analyst. Further, in every analysis there will be unanalysed areas, even some important areas. This is inevitable, given the limitations of character in the two people. Related to this is the fact that it is not possible for any analyst to hold a neutral stance in relation to his patients, or even in relation to particular aspects of a patient's character as they are manifested in the consulting-room. I think nowhere does this show itself more than in attitudes to pleasure.

The last myth that I want to explode is that the patient needs the analyst, but not the other way round. The analyst does need his patients, and I have not found this more clearly stated than in the paper by John Klauber entitled 'Elements of the Psychoanalytic Relationship and Their Therapeutic Implications':

> Patient and analyst need one another. The patient comes to the analyst because of internal conflicts that prevent him from enjoying life, and he begins to use the analyst not only to resolve them, but increasingly as a receptacle for his pent-up feelings. But the analyst also needs the patient in order to crystallize and communicate his own thoughts, including some of his inmost thoughts on intimate human problems which can only grow organically in the context of this relationship. They cannot be shared and experienced in the same immediate way with a colleague, or even with a husband or wife. (1976, p. 46)

It is only to a patient that an analyst can say certain things, and it is often crucial for his own development that he does say them. Closely related to this point is the fact that the patient also acts as therapist to the analyst. I want to quote here the first paragraph of Harold Searles' article 'The Patient as Therapist to His Analyst':

> This paper is devoted to the hypothesis that innate among man's most powerful strivings towards his fellow men, beginning in the earliest years and even earliest months of life, is an essentially psychotherapeutic striving. The tiny

> percentage of human beings who devote their professional careers to the practice of psychoanalysis or psychotherapy are only giving explicit expression to a therapeutic devotion which all human beings share. As for the appreciably larger percentage of human beings who become patients in psychoanalysis or psychotherapy, I am suggesting here not merely that the patient wants to give therapy to, as well as receive therapy from, his doctor; my hypothesis has to do with something far more fundamental than that. I am hypothesizing that the patient *is ill because, and to the degree that,* his own psychotherapeutic strivings have been subjected to such vicissitudes that they have been rendered inordinately intense, frustrated of fulfilment or even acknowledgement, admixed therefore with unduly intense components of hate, envy and competitiveness; and subjected, therefore, to repression. In transference terms, the patient's illness expresses his unconscious attempt to cure the doctor. (1975, p. 103)

I have been cured of deficiencies of character by patients. It has also been clear to me that when I have allowed a patient to heal some character defect of mine, the experience has been enormously enhancing to the patient's ego. The patient definitely gains in ego strength. In particular I have found that this process happens towards the end of an analysis. The patient needs to cure the analyst of a character defect so that the analyst can analyse some element that has eluded effective interpretation until that time; and so that the patient can have the experience of giving something of real value to the analyst. This then becomes an act of gratitude on the patient's part.

The quality which every patient needs of his analyst is self-knowledge. No one knows himself entirely, because every human being is in a constant state of development. What the patient wants to find in his analyst is a process of self-knowledge that accompanies his, the analyst's, development. In the absence of this it is difficult to believe that an analyst can analyse effectively. In the absence of self-knowledge an identification with an ego ideal is substituted, which shrouds the person from self-knowledge. Lacan, for instance, was violently anti-authoritarian and declaimed against the International Psycho-Analytical Association, yet when he was in authority over his own society he was enormously authoritarian, seemingly without knowing it. There are blind spots in all of us, sometimes in areas of importance; but when the blind spot is as gross as in the example just quoted it is difficult to have any confidence that such a person could be a good mediator of the psychoanalytic process.

Lastly, I want to return to the theme with which I opened these lectures: the central importance of truth. Ultimately the mind is healed by truth. This comes before all technique or theoretical approaches, and I have always found that when things have gone seriously wrong it is the baseline to return to and I have never found it to fail. Truth is not the same as honesty; the latter can be in the service of sadism, but truth is servant to no person or thing. It is closely wedded to love and to goodness, which is the *wholeness* of the human person. Psychoanalysis is a servant in that human struggle after goodness. Psychoanalysis is subordinate to truth; it does not possess the truth but has its place in relation to truth along with the natural sciences, human sciences, art, literature, philosophy and religion.

The truths we seek to express are very deep and yet startlingly simple. At the end of a long analysis a patient said to me that he had not heard me say anything which he could not have heard from his mates in the local pub. When I heard this I thought perhaps I had at last begun to become an analyst. There is nothing that I have said in this last lecture that is not extremely obvious; but as I said at the beginning of the series, in the last few years I have come to the conclusion that it is very well worth while stating the obvious.