1

Preliminary thoughts on learning from the patient

> 'However experienced we are we still know very little indeed about how to bring up children, of whatever age. We are beginning to know that we do not know – that is something.' (Bion 1975:147)

The helping relationship re-examined

There are many different caring professions, but the psychodynamics of any helping relationship may be universal. It is important, therefore, to become familiar with the ways in which 'helper' and 'client' interact and communicate to each other.

For this study I use the analytic consulting room as a setting in which we can examine the therapeutic relationship, looking in particular at the patient's perception and unconscious monitoring of the therapist.

Many of the examples I give are from sessions with people who were seen once or twice a week in analytic psychotherapy. Most of these people (had they been differently referred) could have found themselves with a social worker or counsellor, a doctor or priest, or intermittently in a mental hospital. Some of the work discussed was with patients who were seen more than twice weekly; a few were seen five times a week. In Chapter Two, example 2.4, I give a clinical illustration from my own earlier experience as a social worker.

My focus throughout is more on technique than on theory.

But I do not wish to define or to prescribe ways of working which others should follow. Instead, I raise issues and questions, the answers to which will often lie in the work experience of the individual practitioner. From this, I hope others will also learn to learn from their patients, and to tune more finely their own technique to the changing needs of the individual patient.

For the ease of writing I shall not always refer to the therapist as 'him or her'. Instead, I will often use 'him' as a short-hand and other variants will be treated similarly. Likewise, I frequently use 'therapist' to stand for any professional helper who works psychodynamically. The exceptions are when I am referring specifically to a psychoanalyst seeing a patient in five-times-a-week analysis, or a social worker seeing a client.

Psychotherapy: a world of paradox

There are many paradoxes in psychotherapy. I will mention just a few.

For each person there are always two realities – external and internal. External reality is experienced in terms of the individual's internal reality, which in turn is shaped by past experience and a continuing tendency to see the present in terms of that past. Therapists, therefore, have to find ways of acknowledging both realities and the constant interplay between them.

There are many different ways of remembering. In everyday life, memory is usually thought of as conscious recall. When unconscious memory is operating another kind of remembering is sometimes encountered – vivid details of past experience being re-lived in the present. This repetition of the past is by no means confined to good times remembered, as in nostalgia. More often it is what has been fearful in the past that is re-experienced in the course of analysis or therapy. This is believed to be because of an unconscious search for mastery over those anxieties which had earlier been unmanageable.

Nobody can know his or her own unconscious without help from some other person. Repression maintains a resistance to what has been warded off from conscious awareness; and yet,

clues to unconscious conflict still emerge in derivative forms which another person may be able to recognize. If this unconscious communication can be interpreted in a meaningful and tolerable way to a patient, what previously had been 'dealt with' solely by repression can begin to enter conscious awareness and become subject to conscious control or adaptation: 'Where id was, there ego shall be' (Freud 1933:80).

It is usual for therapists to see themselves as trying to understand the unconscious of the patient. What is not always acknowledged is that patients also read the unconscious of the therapist, knowingly or unknowingly. Therapists can no longer claim to be the blank screen or unblemished mirror, first advocated by Freud, because they too are people and no person can be blank or unblemished. Every analyst and therapist communicates far more to the patient about himself than is usually realized. It is important to take this clinical fact into account.

Therapists try not to make mistakes, or to get caught up in defensive behaviour of their own. There will, nevertheless, be occasions when this happens. Frequently, patients make unconscious use of these mistakes in ways that throw new light on the therapeutic process. The ensuing work with a patient is often enriched by the experience of the therapist being able to learn from the patient. In this way the therapy is restored from what might otherwise have become seriously disruptive.

In the course of this book I intend to show how I have come to deal with some of these issues in my everyday work, by formally developing a process of internal supervision, analysing from the patient's perspective what I think is happening. It is this process of internal supervision, and learning to listen, that I wish to share with the reader. I believe that this offers ways out of the many dilemmas that are inherent in psychotherapy.

Knowing and the use of not-knowing

Therapists sometimes have to tolerate extended periods during which they may feel ignorant and helpless. In this sense students are privileged: they have licence not to know, though many still succumb to pressures that prompt them to strive to appear certain, as if this were a mark of competence.

The experienced therapist or analyst, by contrast, has to make an effort to preserve an adequate state of not-knowing if he is to remain open to fresh understanding.

Bion, perhaps more than anyone, was explicit about the need for openness to the unknown in every individual. He did not advocate any comfort in knowing. Instead, he was clear about the anxiety with which analysts can react when they are genuinely faced by the unknown. He said: 'In every consulting room there ought to be two rather frightened people; the patient and the psycho-analyst. If they are not, one wonders why they are bothering to find out what everyone knows' (Bion 1974:13).

Analytic theories are built up to define more clearly the framework in which analysts and therapists work. These are necessary, if analytic interpretation is not to become a matter of inspired guesswork. Theory also helps to moderate the helplessness of not-knowing. But it remains important that this should be servant to the work of therapy and not its master.

Freud described the tendency towards dogma in his paper 'The Future of an Illusion': 'And thus a store of ideas is created, born from man's need to make his helplessness tolerable' (Freud 1927:18).

It is all too easy to equate not-knowing with ignorance. This can lead therapists to seek refuge in an illusion that they understand. But if they can bear the strain of not-knowing, they can learn that their competence as therapists includes a capacity to tolerate feeling ignorant or incompetent, and a willingness to wait (and to carry on waiting) until something genuinely relevant and meaningful begins to emerge. Only in this way is it possible to avoid the risk of imposing upon the patient the self-deception of premature understanding, which achieves nothing except to defend the therapist from the discomfort of knowing that he does not know.

By listening too readily to accepted theories, and to what they lead the practitioner to expect, it is easy to become deaf to the unexpected. When a therapist thinks that he can see signs of what is familiar to him, he can become blind to what is different and strange.

Similarity and sameness

It is a fact of the unconscious that, in any unfamiliar situation, elements that can be regarded as familiar are responded to as signs. They can be seen as warning signals, that a bad experience could be about to be repeated. They may also be seen as signs of security. Either way, the unknown is treated as if it were already known.

It is possible to see these responses in the phenomenon of transference. A patient is confronted by the unknown in the therapist, whom he seeks to know in order to lessen the anxiety of being in the presence of someone who remains unknown. The therapist will also sometimes react to the unfamiliarity of the patient in terms of what is already familiar. Everyone finds it easier to respond in this way – thinking that the unknown is already known and therefore can be understood – rather than to remain in a more prolonged state of not-knowing.

Bion encouraged analysts to hold together their knowing and not-knowing in what he called 'binocular vision' (Bion 1975:63-4). The analyst can learn to follow with one eye those aspects of a patient about which he knows he does not know, while keeping the other eye on whatever he feels he does know. There is a creative tension between this knowing and not knowing.

Sets, subsets and symmetry

When a therapist is confronted by unconscious communication from a patient, he will often encounter elements of primary-process thinking. It is necessary, therefore, to have ways of listening to this that will allow for the paradoxical logic of the unconscious.

In his book *The Unconscious as Infinite Sets* (1975), Matte Blanco[1] uses two concepts from the mathematics of set theory which elucidate in an interesting way these issues of similarity and sameness.

One concept is that of 'set', defined as a collection of all things that have a common element. So we can construe, for instance, a set of all cats. There can be a subset to this of all black cats. We can also, if we like, construe a set of all black things, with a subset of all black cats.

Another concept that Matte Blanco uses is that of 'uncon-

scious symmetry'. This postulates a kind of logic which is basic to primary-process thinking. Unconsciously, we assume all relationships to be symmetrical. For instance, if John is angry with Mary, Mary is unconsciously experienced as also angry with John: they are linked by the relationship of anger. If John is to the left of Mary, in primary-process thinking Mary can equally be to the left of John: they are linked by the relationship of side-by-sideness. Similarly, if Mary is the mother of John, in this 'logic' of symmetry John can also be the mother of Mary: they are joined by the relationship of mother/child. The baby thus creates the mother who creates the baby, and vice versa. Likewise, the baby feeds the breast that feeds the baby.

There can be innumerable applications of symmetry in psychoanalytic listening, and in clinical experience. 'Self' and 'other' may be interchangeable, and this is true of patient and therapist. The part is often equated with the whole, the part-object with the whole-object. Similiarly, 'inside' and 'outside' are frequently treated as the same. As Freud pointed out, in the unconscious there is neither negation nor contradiction. There is also no concept of time (Freud 1915:187).

Sets, transference and countertransference

If transference is considered in terms of unconscious sets, one can often identify what triggers this process. There is then an expectation that the present will be like a similar situation belonging to a previously formed unconscious set.

The sense of similarity, between past and present, can be initiated by either patient or therapist. Most often it has been thought of as the patient attributing elements of past experience to the therapist, or the therapeutic situation, and then responding to this as if the past had spilled into the present. It is, however, evident that the trigger for transference can also be unwittingly created by the therapist behaving in a way that echoes some aspect of the patient's past.

We could illustrate these phenomena diagrammatically by two circles *(Figure 1)*. If one circle is used to represent a set of 'present experience', and the other a set of 'past experience', anything in the area of overlap can be regarded as belonging

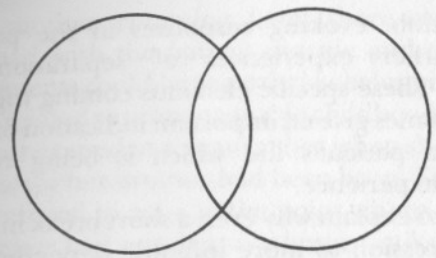

Figure 1

to either set. (This overlap may represent a similarity between the past and present of the patient, or of the therapist.)

From a conscious viewpoint, whatever the similarity may be, past and present can still be distinguished as different. However, because there is no sense of time in the unconscious, anything in the area of overlap can be seen unconsciously as belonging equally to the past or to the present. It is this mis-perception of similarity as sameness that brings about the phenomenon of transference, whereby previous experience and related feelings are transferred from the past and are experienced *as if* they were actually in the present. This is why the phenomenon of transference can have such a sense of reality and immediacy.

There may be a similar unconscious overlap between the experience of 'self' and 'other'. What comes from whom, in any two-person relationship, is not always clear. This is because the processes of communication can be either projective (one person putting into the other) or introjective (one person taking in from the other).

As well as responding to objective elements of similarity, patients also respond to their perception of external reality in terms of their changing inner states of feeling. For example, a patient may become aware of a growing dependence upon the therapist. This can evoke an unconscious set to which other experiences of dependence belong. The patient's internal reality (particularly in the clinical setting) may be seen to include additional elements being currently linked, such as feelings of dependence being associated with an actual separation pending. This can result in a more specific subset around

that conjunction, evoking responses in the patient which duplicate earlier experiences of separation-at-times-of-dependence. These specific elements coming together in the present sometimes give an important indication of the particular time in a patient's life which is being re-lived in a transference experience.

This helps to explain why even a short break in the therapy, during a regression to more infantile dependence, is often more traumatic to a patient than a long holiday had been earlier in the therapy. Some people expect patients to be able to draw upon the fact of having coped during an earlier absence of the therapist. Clinical experience illustrates that patients are affected more by the current state of their inner reality than by their adult experiences, however recent.

This re-experiencing of the past is not necessarily confined to the analytic relationship. I shall first give an example of it occurring in a patient's home.

Example 1.1

A patient (Mrs P.) found herself crying in a distraught way after her four-year-old son had gone to bed. She could not think what had come over her. Her associations to this incident included the fact that her son had been very difficult earlier in the day. He would not do what she asked him. She had told him to go to his room, and when he refused she had screamed at him. He had then obeyed her and was no further trouble.

Mrs P. thought that her crying had had something to do with this incident, but she wondered why it had upset her so much. It was particularly strange as her son had been quite all right later on. She wondered if it had to do with the fact that he had not been able to settle for the night until she suggested that he get into his father's bed, after which he had gone straight to sleep. It was only then, when she was on her own, that she had become so extremely upset.

Discussion: If we abstract the themes in this sequence we can see the triggers to the distraught crying more clearly. There was a mother/child relationship, with a child being difficult to handle and a mother screaming. Later, there were two people together in bed with the patient outside and crying. These particular elements could be regarded as belonging to familiar subsets, each related to unmanageable childhood experiences.

Mrs P.'s mother used to scream at her when she was difficult to deal with, after her brother had been born. Eventually, the patient had refused to eat – to the point where (at the age of four) her mother had sent her to a home until she recovered her 'correct weight'. The memories evoked by the coming together of these specific elements in the present included that of her brother being allowed to stay with her mother, here represented by the son allowed to be alone with his father.

The concepts of sets and symmetry can help us to see that the patient, as a screaming mother, evoked in herself an identification with her son as the child being screamed at. Secondly, the excluding relationship (which in childhood had been that of mother with brother) was being unconsciously experienced here as equivalent to the present relationship of husband with son. Each relationship combined the elements of parent/child and an experience of someone being excluded.

(This patient is referred to again in Chapter Six, example 6.4.)

Countertransference responses to the familiar

Therapists are trained to monitor their countertransference responses to a patient so that they do not respond inappropriately to a patient as to a 'transferential object'. (I discuss other aspects of countertransference in Chapter Four.)

I wish to suggest that, in one important respect, patients continue to be exposed to unacknowledged countertransference activity by the therapist. This is because therapists tend to develop an attitude (not unlike a transferential relationship) to their own theoretical orientation or clinical experience. As with transference, there is a tendency to experience a feeling of *déjà vu* when there are elements of similarity between a current clinical situation and others before it. This can prompt a therapist to respond to new clinical phenomena with a false sense of recognition, drawing upon established formulations for interpretation. The unconscious dynamics that contribute to this 'countertransference response to the familiar' include

the therapist's anxiety, and a need to feel more secure, particularly when under stress with a patient. There is also a natural investment in one's own way of interpreting.

Example 1.2

In a series of clinical seminars, in which we were looking at 'failed cases', the following interchange between a therapist and patient was reported. A female patient had been in twice-a-week therapy for three months with a male student therapist. Clinical material was presented from the penultimate session before the therapist was due to go away for his Easter holiday.

Patient: 'You will have to listen to me with extra care to-day because I have just been to the dentist. His drill slipped and he has hurt my tongue. It is difficult to talk.'

Therapist: (relating this immediately to the pending break): 'I think you are afraid I will be careless with you; that I may not exercise enough care with you with regard to my Easter holiday, so that my words could bore holes in you and leave you feeling hurt when I have gone.'

Patient: 'No, not at all.' (Silence.)

Therapist: 'I think you are using the silence as a way of leaving me before I leave you.'

Patient: 'No. In fact I was thinking of leaving therapy anyway. I think things are better. My outside relationships are better.'

Therapist: (prompted by a recent seminar on ending therapy): 'Do you feel this improvement is due to work we have done together, or do you see this as your own achievement?'

Patient: 'I see it as my own achievement.'

The therapist was able to persuade the patient to allow some time to think over this sudden decision to leave therapy. In the next session the patient told her therapist she had decided that she could not afford her therapy any more. She could spend the money she would save on a course for learning to teach English to foreigners.

Discussion: The patient began by telling the therapist there had been some kind of injury, which now made it difficult for her to speak to him or to make herself understood. The therapist did not appear to recognize any derivative communication in what the patient was saying to him. ('Derivative communication' is used to mean the indirect communication of thoughts or feelings unconsciously associated to, or derived from, whatever has primarily provoked them.)

The therapist listened mainly in terms of theory, and a premature assumption that this patient was referring to the pending holiday break. Even if this interpretation could have been correct in content, it was wrong in timing. By butting in here, the therapist leaves no space for the patient to experience what is described. By pre-empting the patient's possible anxiety about the therapist becoming careless, the therapist ironically then *becomes* careless.

Let us again abstract the themes. The therapist accepted the reference to a current carelessness as referring to the dentist. But, if we again think in terms of sets, the careless dentist belongs to a set of 'careless professionals' to which the therapist could also belong if he had been experienced recently as careless in the therapy.

By intervening too quickly, the therapist missed a chance of listening for further leads about an injury, to see whether this referred to him or not. There may be an allusion here to some recent interaction with the therapist in which the patient has felt hurt. If so, this could be making her experience the current difficulty in communicating with him. If he were to recognize the less obvious communication to him it would need special care in listening. The patient tells him so.

The therapist proceeds to relate the patient's opening statements to the holiday break. There is a clinical tradition for thinking of material before a holiday in terms of the break, but here it sounds rather bookish. The patient replies by disagreeing with the interpretation. The therapist responds to the ensuing silence with a further interpretation to do with the holiday break. The communication gap widens.

When the therapist does not understand the patient's allusion to something getting in the way of her communicating to him, even when she has pointed out that he will need to

listen with special care, the patient considers terminating work with this therapist. She rubs his nose in this by saying her outside relationships are going better. A nuance here could suggest that these other relationships are going better than the present relationship inside the consulting room.

The therapist aims to assess the reality of this readiness for leaving. He thus moves into a new gear, which makes it obvious to the patient that he accepts her thought of leaving as virtually decided. The patient presses home her dissatisfaction. The improvement referred to feels like her own achievement, not a shared thing, nor thanks to the therapy. When the patient's decision to end is made final, she offers her therapist a parting comment which may contain the key to her feeling of injury. She is going to teach others to learn her own language (English). There is a sense in this sequence of the therapist having failed to learn her language. Instead he had imposed his therapy-language upon her, feeling prompted to do so by what seemed to be a familiar clinical situation. The traditional responses here, to do with holiday breaks or silences, are therefore not related to the more specific communications from this patient.

It is very easy to make this kind of mistake: and it is not only students who rely upon the understanding of others, and the knowledge of theory, to bolster a feeling of competence. Using a familiar element for orientation amongst the unfamiliar can be misleading, although it may bring some relief. In *Three Men in a Boat* (Jerome K. Jerome 1889), when the three companions were lost in Hampton Court maze one of them noticed that they had passed the same half-eaten bun before. This did not mean they knew where they were; it only demonstrated that they were going in some kind of a circle.

An exercise in interpretive re-orientation

As an analogy, the process of analytic listening and interpretive linking could be loosely compared with that of looking for a sequence in mathematics. The difference, of course, is that with patients we are dealing with human processes that are not susceptible to any such proof or disproof of accuracy.

Let us consider the following sequence:

– – 2 2 4 4 – –

One response could be to interpret this as two pairs: *22 44*. We then have two numerical entities which can be linked by the multiple 2. Equally, however, they could be linked by the addition of 22. We do not yet have enough to go on, to know which sequence this belongs to. If it is the former we would expect to find the sequence to be extended, either before or after, as *11 22 44 88*. If it belongs to the latter we would expect it to be extended as *00 22 44 66*.

If these sequences were to represent clinical material, it would be a grossly premature interpretation to assume the relationship between 22 and 44 to be simply that of one number being twice the other. We need to be aware of the other possibility, so that we will wait for more of the sequence before trying to interpret. After waiting we can more confidently see which of these sequences is more probably being represented.

Let us add to the sequence:

1 22 44 8

We can now eliminate one of the possibilities that had been previously considered; i.e. the sequence is not going to evolve as *00 22 44 66*. Instead, it looks as if it could be *(1)1 22 44 8(8)*; but it might still be premature to think we understand the sequence. For instance, the missing numbers in the sequence could turn out to be as follows:

61 22 44 89

We would then have to abandon all assumptions we have made so far, being back in the area of not-knowing; and the sequence has to be returned to a state of apparent non-sense, as *6 1 2 2 4 4 8 9*.

If this were clinical material, once again we would have to listen to more of the sequence. We would also need to allow passive re-call of prior details which might contain elements of the same sequence. If we add to this now, before and after, we could have the following:

3 6 1 2 2 4 4 8 9 6

At first sight this might look like a meaningless sequence of random numbers. However, if we look at it from a different viewpoint, we can discover that it makes sense if we rearrange it around a new axis. What had seemed to be non-sense will become meaningful if we break it up thus:

3 6 12 24 48 96

The above illustration, like any analogy, has its shortcomings. Of course no psychoanalytic listening can be so mechanical, nor should it be regarded as absolutely right or wrong. Nevertheless, the illustration does represent the clinical experience of discovery that follows when we realize that we have missed something essential, when our initial assumptions are not borne out by what follows later in the sequence — or what may have gone before (perhaps unnoticed).

Re-orientation in a session

When in a session with a patient it can be important to sustain a sense of not-knowing, beyond the initial impression of having understood. Often the patient will provide the missing factor(s) that can point to the unconscious meaning which hitherto had remained elusive. I will illustrate this from the work of a female therapist.

Example 1.3

A patient of twenty-five was in her second year of three-times-a-week therapy when she became pregnant. As the elder of two sisters she had longed for this, her younger sister already being married with a child.

During the first months of the pregnancy the patient had treasured the privacy of her personal secret. No-one knew about this except her husband, her GP, and her therapist. Her secrecy was important to her because she had suffered all her life from her mother's intrusive attempts to control every aspect of her existence. Her marriage had helped to establish a much needed separateness from this widowed mother; and the patient had chosen to live at a sufficient distance from her to limit the mother's tendency to interfere.

The patient had been carefully preserving this period of privacy concerning her pregnancy, for as long as this could be prevented from becoming public knowledge. She then came to a session in great distress. Her sister had just been to see her and had guessed she was pregnant. She had directly challenged the patient, who felt obliged to tell her. She was now so upset because her mother would have to be told too, and the timing of this had been forced upon her by circumstance.

Since the moment when her sister had asked about the pregnancy the patient had had a splitting headache. Her therapist interpreted this in terms of the patient's familiar anxiety that once again her mother could become an intrusive influence in her life. The patient agreed. She had hoped to have had at least another month before having to resume dealings with her mother. The pregnancy had been her first experience of real privacy from her mother's compulsive interference. Even her marriage had not been immune from that. Her headache continued to be very painful.

Silent reflection: The therapist was reminded, by the patient's allusion to the marriage, that there had been similar anxieties then. The patient had experienced her future husband as threatening to invade her. Having only just begun to win some mental and emotional space from her mother, the patient had become afraid she might be about to lose this to her husband; and her marriage could become just another version of being owned by someone else, unconsciously representing her mother.

When the therapist thought about this reference to the patient's marriage she felt prompted to re-orientate her listening around the issue of pregnancy. Until then, she had been regarding the headache as a symptomatic expression of the patient's fear of being taken over again more directly by her mother. She had not perceived this as an allusion to her un-born baby. This was already inside the patient's body. Could it be that the patient was unconsciously experiencing

the baby as representing her mother taking her over from inside?

> The therapist offered a tentative interpretation. Could the patient be experiencing her baby as a threat, perhaps as an embodiment of her mother's invasiveness which previously she had been trying to combat externally?
>
> The patient was able to think around this for herself. Yes, she believed this could be true. She had been afraid of being invaded physically, and of being taken over emotionally, when she got married. The baby could be an even greater threat to her, on the same two counts. It was as if she could never get away from her mother, and she could not get away from her own pregnancy. She was afraid of damaging her baby by hating it as a representation of her mother.
>
> After a silence, the patient elaborated further: she said it felt like an unthinkable thought that she could hate her own baby. She added that perhaps her headache had been an expression of the conflict between her protective love for the baby and her life-long impulse to get away from anything threatening to invade her privacy. She continued to think aloud around this. For her, it was an entirely new discovery that she could have hostile feelings towards the baby she so much wanted.
>
> Later in the session she realized her headache had lifted for the first time in several days. She felt convinced that this conflict in her feelings about the baby had been the key to her headache, which both the therapist and she had been missing until then.

Discussion: As a result of following the patient's cues, it became possible for the therapist to recognize that the current conflict might have to do with the baby. It was as if her baby might represent a 'Trojan horse', by which all she had most feared from her mother could take her over – literally from within. The patient's subsequent realization that she could hate her baby, as well as love it, carried the conviction of discovery. It

was after all her own; the thought had not been put into her by the therapist.

The patient would have been let down if her therapist had continued to work over the patient's more direct and conscious fears concerning her mother. Equally, if the therapist had interpreted earlier the likelihood of the patient having ambivalent feelings towards her baby, that insight (though true) would have been premature and persecutory to the patient. In this case the therapist's slowness allowed time and space for the patient to arrive at this realization for herself, in a way she could tolerate and make her own.

Insight offered or imposed?

When patients feel they are not being understood, it is not always easy for them to communicate this to someone whose professional claim is to know about these things. The patient may also encounter the ultimate and irrefutable reply, that if the patient does not know something consciously it is because the patient is unconscious of the alleged truth being offered by the analyst. But it is not always just offered. It is sometimes dogmatically stated; and even a patient's rejection of an interpretation can be invoked as proof of its truth, and as evidence of the patient's defensiveness in response to it.

The analyst or therapist, as an implicit prophet of the unconscious, has a position of power in these matters which he must handle with great caution. Some patients do not find it easy to stand up to a therapist. Nevertheless, because they cannot always be right, therapists need help from the patient's cues towards better understanding. These cues are most often oblique rather than direct, unconscious rather than conscious.

In trying to understand the patient, a therapist waits until he feels that he can recognize a thread of meaning that can be identified and interpreted. But, in this work of interpreting, how can therapists avoid imposing their own theoretical bias upon their patients? Bion advocated that an analyst should approach each session without desire, memory or understanding (Bion 1967a; also 1967b:143-45). The desire (for instance) to cure or to influence, the active remembering of the previous session, and the illusion of understanding in terms of what is theoretically familiar, all contend against the kind of openness

to the patient's individuality that is the hallmark of psychoanalysis at its best.

Whose resistance?

When a patient fails to acknowledge some truth about himself, as presented by the therapist, or agrees verbally without any significant shift in his life or in the therapeutic relationship, it is common to regard this as due to unconscious resistance within the patient. It may be so; but sometimes it can be an indication that there is, in this lack of change, an unconscious cue to the therapist to re-assess his assumptions about the patient, his theory or his technique. There may be something the therapist has not yet recognized, or acknowledged, and the therapist can be resistant too. Listening for unconscious symmetry in the patient's communications can often help to indicate what it is that has been overlooked. Potential stalemate in a session may then lead on to renewed movement.

Example 1.4

At a clinical seminar a female therapist discussed some work involving a male patient who continually shouted. In presenting a session, the therapist demonstrated this shouting to the seminar group. We were told by the therapist that she had tried many times, and in many ways, to understand this behaviour in the therapy. So far, nothing had helped it to alter.

When one member of the seminar group asked the therapist how she felt about being shouted at in this violent-sounding way, she replied: 'Well, one thing I know about myself is that I don't have difficulties with aggression or violence.'

Discussion: By listening to the interaction here in terms of symmetry, we could formulate that *someone* was failing to get through to *someone*. What we had been assuming, previously, was that the therapist had been failing to get through to the patient – hence no change. But the interaction took on a fresh perspective once we realized the patient could be failing to get

through to the therapist. Perhaps the shouting was an attempt at achieving this.

We could also wonder whether the therapist was only able to cope with being with an aggressive (even violent) patient by shutting off a part of her own responsiveness. The group had felt far less comfortable about the shouting than the therapist. So, if the patient were trying to get through to the therapist (but was failing to do so) perhaps he was demonstrating exasperation, or despair of being heard, by shouting louder.

Having considered that the resistance producing the stalemate might partly be coming from herself, the therapist reflected upon this and became more able to hear what previously she had been missing in her patient's communication. She later reported to the seminar group that the patient had quietened down. The patient was now feeling heard.

The issue of control

It is easy to rationalize that patients should not be allowed to control their own therapy, as if this might 'render the therapist impotent' – to use a familiar phrase. But if the therapist insists on controlling the entire therapy, might that not equally render the *patient* impotent? Sometimes, of course, a therapist has to stand firm with a patient. There are also times when a patient has to stand firm with the therapist, in the name of his or her own truth. Such occasions can be misunderstood if a therapist is anxious about being manipulated or controlled by the patient. This often indicates that a therapist is feeling under stress; in which case it is usually more fruitful to listen to the sense of pressure, as an unconscious communication from the patient, rather than to react to it prematurely around an issue of control.

The therapist's responsiveness to cues from the patient

Several patients have pointed out how they first became able to trust me through discovering that I was willing to learn from them. For some this may be how they first come to find a basic trust. Unless this is rooted in experience it can remain an insubstantial hope.

Example 1.5

Early in her analysis Mrs B. (who had been severely burned when she was eleven months old) was telling me that the continuing pain from this experience and the attendant memories were making her hair go grey. I began looking more closely at her hair (over the back of the couch) to see if I could see signs of this greying. When I could not see any trace of this, I wondered whether it was an invitation for me to be closer to the patient. Perhaps if I were *very* close to her I would be able to see *some* grey hairs. I began to explore this as an appeal for me to be closer, thinking (to myself) that the patient was trying some hysterical manipulation on me.

Mrs B. became very distressed. When I listened to her distress, which was a crying from deep inside, I realized I had completely missed the point. I had been looking for outward signs of going grey. When I listened more closely I was able to interpret quite differently. The patient had been trying to tell me about her *inside* world, in which the scars from her childhood experiences made her feel that she was growing prematurely old. Part of the problem was that her emotional scars were not visible. She and I were having to deal with those other scars which had not yet healed.

Discussion: Although I had hurt this patient by my misunderstanding, by my focusing on the outside (where others too had found their reassurance that she had recovered from the accident), I was given an opportunity to be guided by the patient to recover from my mistake. She gave me another chance. This time I was able to recognize what she had been trying to tell me, in her enigmatic reference to her greying hair, and it turned out to be an important moment in her analysis. Mrs B. frequently referred back to this occasion. She told me that this was when she had begun to believe she could risk some dependence upon me. I had let myself be guided by her, which meant I could learn from her.

After her accident, Mrs B. had felt that her mother no longer seemed able to respond to her cues, or to her needs, in the same way as before. It was therefore crucial to her that I

was learning to follow the cues she gave to me; and this became the basis for much of what later emerged in her analysis.

(This patient is referred to again in Chapters Five and Seven.)

I have noticed that as I have learned more about psychoanalysis, and about being a therapist, I have also become able to learn more from my patients. This has made me wonder about the different quality of relating that has resulted from this.

With some patients I have had to rely much more upon what I already know from the theory of psychoanalysis, and what I have learned about analytic technique, for that is often how I find (or maintain) my role. With them I have gone more by the book than by intuition, and I have remained more classically the same. With other patients, particularly with those from whom I feel I have learned most, I have found myself becoming responsively different to each of them. What does this imply? Which group of patients might be said to have had the better analytic experience: those with whom I preserved myself more firmly the same, or those in response to whom I allowed myself to be moulded into a more individual analyst?[2]

I have no easy answers to these questions. I can only eliminate the obvious extremes. If firmness becomes rigidity, it offers a false security to analyst and patient alike. On the other hand, the opposite extreme of an unreflecting flexibility amounts to 'wild analysis' with serious risks of unresolved countertransference difficulties being acted out within what is meant to be a therapeutic relationship (see Chapter Three for an example of this).

There remains a type of analytic inter-relatedness, that can be seen more clearly in some analyses than in others, but which may be a factor in all. I am thinking here of certain parallels with the parent-child relationship, that is so often presented for sorting out in the course of an analysis. To illustrate this I shall briefly digress.

Analysis and the nursing triad

Growing children need their parents to be able to respond differently according to different developmental stages. For

example, a mother has to learn her infant's language if she is to respond according to the varying needs of her baby. Some mothers develop more skill in this than others. This difference has many determinants. There is the mother's own experience of being mothered; this will have left a set of images of mothering in her mind. A mother-to-be also has her own innate potential for being a mother to her baby; this potential can either be realized, or it can be interfered with.

From reading Winnicott I have come to think in terms of a 'nursing triad', whereby the mother is emotionally held while she holds the baby. The biological father may be absent, but there needs to be someone in the new mother's life whose chief function is to be there to support the mother-and-baby as they begin to get to know each other. In particular the new mother needs to be believed in as capable of being a 'good enough mother' to her own baby (Winnicott 1958:245).

Where this holding of the mother (as mother to her baby) is absent, there can be serious disruptions of the subsequent mothering. If the mother feels undermined as mother she may begin to resent her baby, which can come to represent her sense of failure as a mother. (Society sometimes reinforces a mother's insecurities here, when attention is more often focused on the mother than upon those who have failed to give her the support she has needed.) This lack of confidence in herself can be aggravated by other people's readiness to tell her what to do, and by others taking over and seeming to be better mothers to her baby. There may also be an internal erosion of confidence from bad childhood experiences of being mothered, or (in the present) of not being believed in or supported as a mother. Added to that there is sometimes a persecutory awareness of the baby's failure to thrive or to feel secure in the mother's handling. All these factors can contribute to a tendency to neglect the baby, even to give in to impulses to attack a baby who represents an attack upon herself as a mother.

If, on the other hand, a mother feels adequately held (as mother to her baby) she is more able to learn from her baby how best to be the mother which, at that moment, her baby most needs her to be. To begin with, this means learning her

baby's language and individual rhythms; and these will not be the same as in the books, or the same as the baby next door, or the average baby that some child experts seem to speak of (with their 'milestones' and so on). These will also not be the same as in the case of any other baby that the mother previously may have had. Each baby is different.

A mother who thus allows herself to respond to the individuality of each of her babies will, in some measure, find herself being a different mother to each. She will also find herself changing with time, through her continuing to learn from her baby/child in response to changing developmental needs (Winnicott 1965b:Chapter 7).

The father (or father substitute) comes into this too. From the beginning that holding presence is of crucial importance to the mother, and the child benefits or suffers according to the quality of that support. The 'father' later comes into a different role, as the child moves into discovering about triangular relationships. Still later the adolescent presents different needs again, requiring a firmness which 'belongs to containment that is non-retaliatory, without vindictiveness, but having its own strength' (Winnicott 1971:Chapter 11).

The patient, the analyst and the internal supervisor

I have covered the above, familiar, ground in some detail as I believe that similar dynamics apply in the analytic relationship. We can see this most clearly in relation to students.

Student analysts and therapists have a particular need to be professionally held while they learn about the analytic holding that a patient needs in therapy. They should be able to draw upon the experience of their own analysis; they can also be held by their knowledge of theory and of technique, to have the security to continue to function analytically even under pressure. But, in addition, there needs to be a supervisory holding by an experienced person who believes in the student's potential to be in tune with the patient and to comment helpfully.

However, students need to be able to develop a style of working which is compatible with their own personality; so

there will be something essential missing if he or she becomes too much of a *pastiche* of the training analyst, or the supervisor, however unconscious that may be.

Amongst the pitfalls of a supervisor (and here I draw upon what I have learned from those I have supervised) is the danger of offering too strong a model of how to treat the patient. This can mislead students into learning by a false process, borrowing too directly from a supervisor's way of working rather than developing their own. Some students can be seriously undermined in this way, feeling as if the treatment (or even the patient) has been taken over by the supervisor.

Here there are echoes of the mother who feels she is being told how to be a mother, and the results can be similarly disturbing to the student's analytic attitude towards the patient. For, if a patient comes to represent the student's difficulties in believing in himself as a therapist, he will have problems in working with that patient.

Winnicott was careful always to respect a mother's understanding of her own child. He therefore used to emphasize that he was only an expert on mothers and babies in general. Although he might be useful to a particular mother, it was she who continued to be acknowledged as the person who knew her own baby better than anyone else (Winnicott 1965a: Chapter 1).

As with the mother, this holding of the student therapist is first experienced as coming from outside. Transitionally the experience of supervision is usually internalized. Ultimately this needs to develop into an internal support that is autonomous and separate from the internalized supervisor. So, in order to emphasize this further development, I have come to think in terms of an internal supervisor (see Chapter Two).

When the internal supervisor remains poorly individuated there is a tendency for therapists to rely too much upon the thinking of others. But, any strong adherence to a particular school of theory, or position on technique, can itself become intrusive. The analytic process can easily become tilted in a pre-determined direction, which means it then ceases to be truly exploratory or psychoanalytic.

It is not surprising that the critics of psychoanalysis can point out how Freudian patients seem to have Freudian dreams, whereas Jungian or Kleinian patients are said to have dreams that fit in with the different theoretical position of *their* analysts. Here, I think, we have evidence of patients being taught to speak the language of the analyst; and not only language. Parallels may be found, among analysts and therapists, with mothers who assume they know best what their baby needs. We also hear of mothers who did not trust their own judgement sufficiently, having been misguided by authorities on child-rearing (Truby King among others) into believing they could bring up their babies by the book rather than 'by the baby'.

If 'the book' is given too much importance, then the choice of book becomes a crucial issue. Many bitter controversies might have been avoided if more analysts had questioned their belief in the over-riding importance of a fully integrated theory.[3] When analysts and therapists go rather more 'by the patient', and less by the particular theoretical orientation by which they feel supported, it becomes easier to notice when a patient feels out of tune with what is being said or with how the analysis is being conducted. Some patients may need a different style of analysis. It is important that therapists leave themselves room in their technique to allow for this. The analytic process becomes seriously restricted if therapists define themselves out of this possibility in the name of their own chosen orthodoxy.

In order to guard against the distorting influence of theoretical bias I find it useful to keep asking myself two questions, before and after interpreting or when supervising: (1) 'Is the patient's individuality being respected and preserved, or overlooked and intruded upon?'; (2) 'Who is putting what into the analytic space, at this moment, and why?'

Psychoanalysis has the potential for enabling a re-birth of the individual personality. It is a tragedy if this comes to be limited to a process nearer to that of 'cloning', whereby the patient comes to be 'formed in the image' of the analyst and his theoretical orientation.

Learning from the patient

In his book *Orthodoxy* (1908), G.K.Chesterton imagines:

> 'an English yachtsman who slightly miscalculated his course and discovered England under the impression that it was a new island in the South Seas... who landed (armed to the teeth and talking by signs) to plant the English flag on that barbaric temple which turned out to be the Pavilion at Brighton.'
>
> (edition 1961:9)

If a therapist trusts in the analytic process he will often find himself led by the patient to where others have been before. The importance for the patient is that any theoretical similarity to what previously has been conceptualized in relation to others shall be arrived at through fresh discovery, not pre-conception.

The therapist's openness to the unknown in the patient leaves more room for the patient to contribute to any subsequent knowing; and what is thus jointly discovered has a freshness which belongs to both. More than this, it may be that a significant part of the process of therapeutic gain is achieved through the patient coming to recognize that the therapist can learn from him or her. The patient is thus given a real part to play in helping the therapist to help the patient and, to that end, to discover what is needed in that patient's therapy.

Patients benefit from a therapist's willingness to find out, even that which is already 'known', through working clinically with them. This feels better by far than using short-cuts to understanding, based on what is borrowed from others – and which patients also borrow. Fresh insight emerges more convincingly when a therapist is prepared to struggle to express himself within a patient's language, rather than falling back upon old thinking.

When I let patients play a part in how their therapy evolves I do not find myself being made helpless because of this. At times I may even have to become drawn into a 'harmonious mix-up' within the analytic relationship (Balint 1968). There are, of course, other times when I have to maintain an adequate firmness, without which a patient could feel insecure and deprived of the opportunity to experience confrontation

with someone clearly separate and different from himself. For instance, when a patient is ready to find a therapist's otherness (or what Winnicott calls 'externality') the therapist has to be able to respond to the patient's attacks, upon him and the therapy, without collapse or retaliation (Winnicott 1971: Chapter 6).

Therapists need confidence in the analytic process if they are to be able to tolerate the vicissitudes of being used by their patients in these different ways. They need to be able to follow the patient, without feeling too much at sea to function analytically. For this they will need an adequate orientation to hold them near enough on course, or to help them back on course when they become lost.

In the treatment setting, it is a function of the internal supervisor to hold the analyst (or therapist) who is learning to hold the patient. This provides the structure of an internal 'nursing triad', which can help the therapist to find an inner play-space where the clinical options can be explored (silently or with the patient) rather than remaining blinkered by past thinking that often functions too much like a set of rules.

In the rest of this book I intend to examine various aspects of the interaction between a patient and the analyst or therapist. It is my belief that therapists could risk being less tenacious in their adherence to particular theoretical positions if they allowed themselves to be more receptively open to what their patients communicate to them at so many diverse levels.

When a therapist learns to follow the patient's cues, and listens to the resulting dialogue between the two viewpoints of 'binocular vision' (Bion 1975), of knowing and not-knowing, he will frequently find himself led towards the understanding which is needed.

Notes

1. I first heard of Matte Blanco's use of these concepts, unconscious symmetry and sets, in a paper presented to the British Psycho-Analytical Society in 1980, by Eric Rayner. A version of that paper has now been published: 'Infinite Experiences, Affects and the Characteristics of the Unconscious' (Rayner 1981).

2. Since writing this chapter, I have been pleased to find Sandler expressing similar thoughts in his paper 'Reflections on some Relations between Psychoanalytic Concepts and Psychoanalytic Practice.' In this he says:

> 'The conviction that what is actually done in the analytic consulting room is not "kosher", that colleagues would criticize it if they knew about it, comes from the reality that any analyst worth his salt will adapt to specific patients on the basis of his interaction with those patients. He will modify his approach so that he can get as good as possible a working analytic situation developing. To achieve this, he needs to feel relaxed and informal with his patient to an appropriate degree, and at times he might have to depart quite far from "standard" technique.'
>
> (Sandler 1983:38)

3. Sandler begins his paper (quoted above) by saying:

> 'If one looks carefully one can find an implicit unconscious assumption in many psychoanalytic writings that our theory should aim to be a body of ideas that is essentially complete and organized, with each part being fully integrated with every other.'

He later continues:

> 'There are advantages to emphasizing the developmental-historical dimension in psychoanalysis when we think of theoretical matters. It allows us to escape – if we want to – quarrels about which theory is "right" and which is "wrong". Rather, it puts us in the position of asking "Why was this, that or the other formulation put forward?" and "What did its authors mean?"'
>
> (Sandler 1983:35)

2

The internal supervisor

Internal supervision: a quest for balance

Therapists are often related to by the patient as a transferential object, representing aspects of earlier relationships, and yet also as a real object. This means that they have to be able to remain well disposed towards a patient even when they are being treated as someone with attitudes that may be quite alien.

In order that a patient can relate to the therapist, as freely as possible in terms of the patient's inner reality, it has long been accepted that the analytic process should be protected from needless interference from the therapist's own personality. However, in order to avoid becoming intrusive in the therapy, some therapists become defensive in trying to be as little in evidence as possible. Unfortunately, falling over backwards (in trying to achieve this) can become just as intrusive as falling forwards into the centre vision of the patient's awareness. As far as possible, the therapist's presence therefore has to remain a transitional or potential presence (like that of a mother who is non-intrusively present with her playing child). The therapist can then be invoked by the patient as a presence, or can be used by the patient as representing an absence.

This is the world of potential space (Winnicott 1971: Chapter 3) which is part real and part illusory, and here I use the notion of illusion as belonging to the experience of playing (ludo = to play). In this space the patient needs to be allowed