

‘TAKING THE TRANSFERENCE’: SOME TECHNICAL IMPLICATIONS IN THREE PAPERS BY BION

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In this clinical paper, the author presents a coherent model for conceptualising the process of establishing a ‘containing object’ in the mind of the analysand throughout the course of analysis. The technical implications offered in this model derive mainly from concepts and notions put forward in three papers by Wilfred Bion and explicated by the present author: ‘A theory of thinking’ (1962/1988), in which Bion emphasises what he calls ‘realistic projective identification’, which functions as an unconscious form of communication to and calls for understanding on the part of the analyst that is aimed towards the development of thoughts and an apparatus with which to think thought; ‘Notes on memory and desire’ (1967/1988), in which he sets forth some ‘rules’ for the analytic work that is centred on the ‘here and now’ of the evolving therapeutic interaction; and his paper on ‘Evidence’ (1976/1987), wherein he focuses on the ‘fact’ of the individual analyst’s emotional experience. The author also demonstrates, through the presentation of four detailed vignettes, some of the ways in which the analytic process may fail or succeed, highlighting the import of the analyst’s capacity for ‘reverie’, ‘transformation’, and ‘publication’—all aspects of the containing function. In addition, she further expands upon Bion’s work with a discussion of the essentials of ‘taking the transference’ and differentiates between two main dimensions of interpretation, ‘projective’ and ‘introjective’.

‘It is no good anyone trying to tell you how you look at things, or from where you look at things—no one will ever know except you’ (Bion, 1976, p. 245).

INTRODUCTION

Early on, Freud (1901) observed that patients suffer from amnesias and then invent paramnesias to fill the gaps. However, as Bion pointed out near the end of his life, ‘It would be so nice if it were only patients who did it, and so fortunate if we did not’ (1976/1987, p. 243). Bion even went so far as to consider the possibility that our analytic theories, indeed ‘the whole of psychoanalysis [might turn] out to be one vast elaboration of a paramnesia, something intended to fill the gap—the gap of our frightful ignorance?’

(p. 244). In his theoretical papers, Bion intentionally left his concepts ‘unsaturated’—full of gaps or perhaps, more accurately, open spaces to be filled in, not by each individual analyst’s paramnesias, but by his/her own individual thoughts derived from the process of ‘learning from experience’ in analysis. In this manner, Bion hoped that each analyst might be more able to forge ‘for himself the language which he knows, which he knows how to use, and the value of which he knows’ (p. 242).

Not unlike a ‘good’ analyst or supervisor, Bion’s body of work has provided a source of inspiration for analysts, especially with regard to their efforts to develop, for themselves, models that conceptualise the analytic process. In constructing my particular model, I have taken into consideration certain aspects of three papers by Bion: ‘A theory of

thinking' (1962/1988), 'Notes on memory and desire' (1967/1988), and one of his last papers, on 'Evidence' (1976/1987). From my point of view, these papers—when considered together—generate some technical implications for Kleinian as well as non-Kleinian analysts, which I will endeavour to outline here.

Throughout these notes I will underscore several aspects of each of these papers, drawing a few very tentative conclusions from them, and elaborating on those concepts of Bion's that I find central to my personal way of working. As I go along I will attempt to demonstrate a number of these ideas with clinical vignettes, emphasising the importance of the development and handling of the earliest infantile transference encountered in the treatment of the sorts of patients that I believe are ordinarily seen in many analytic practices.

BION'S THOUGHTS ON THINKING THOUGHTS

Daring to disturb one of the centrepieces of Klein's (1946) theory, Wilfred Bion courageously expanded and extended the notion of 'projective identification as a defensive phantasy' to include its function as a normal, pre-verbal form of communication between mother and infant. Most notably in his 1962 paper, Bion outlined a 'theoretical system' (p. 178) that he was convinced might apply in a significant number of cases. He began by suggesting that 'thinking' is dependent as much upon the successful development of thoughts as it is upon the growth of an apparatus for thinking these thoughts. Along the lines of Kantian philosophy, Bion considered that thinking is called into existence to cope with thoughts, that thinking is 'a development forced upon the psyche by the pressure of thoughts and not the other way around' (p. 179). As cryptic as this may at first appear, Bion explains himself further on in the paper as he tells us how thoughts first come into being.

Bion clarifies that the baby's inbuilt expectation (or what he called a *preconception*) of the existence of a satisfying breast, when mated with an experience approximating this preconception (which he called a *realisation*), results in a *conception* (or an as yet unnamed concept). Thus, he concluded that a conception is always found in the presence of an actual emotional experience of satisfaction.

In contrast to this situation, the mating of a preconception with a *negative realisation* results in the development of a bad object: a 'no-breast' (p. 180) or the 'presence of an absence' that frustrates. The resultant feeling of frustration—when sufficiently tolerated—leads to the birth of a thought. So here we can see that, according to Bion, a thought is born of frustration that is sufficiently tolerated, or what he later called 'tolerated doubt'. Additionally, since thought acts as a bridge between a felt-want or desire and the action necessary to obtaining satisfaction, the 'capacity for tolerating frustration thus enables the psyche to develop thought as a means by which the frustration that is tolerated is itself made more tolerable' (p. 180).

Bion observed that if tolerance of frustration is inadequate, evasion of frustration, rather than its modification, will be the outcome. In other words, frustration, rather than leading to the development of thoughts, will result in the development of a 'bad object' fit only for evacuation. Now here is where Bion tells us that the mother—the external object—comes into the picture right from the start of the baby's life, and since I am referring to the beginnings of mental life, it is important to consider that the mother plays a significant role in this respect even before birth at around twenty-six to thirty weeks of gestation. For more on this topic, I recommend the work of Mauro Mancina (1981), who has extensively reviewed research regarding the pre-natal mental life of the foetus and its impact on the mental life of the new-born infant.

Regarding the role of the mother, Bion specified that the preconceptions of the baby are concerned with its own survival. However, while noting that the baby’s own personality is one factor that impacts its survival, he clarified that:

The personality of the infant, like other elements of the environment, is [ordinarily] managed by the mother. If mother and child are adjusted to each other, projective identification plays a major role in the management; the infant is able, through the operation of a rudimentary reality sense, to behave in such a way that projective identification, usually [thought of as] an omnipotent phantasy, is a realistic phenomenon . . . As a realistic activity it shows itself as a behaviour reasonably calculated to arouse in the mother feelings of which the infant wishes to be rid (1962, p. 182).

Parenthetically, the reader may notice that this view of Bion’s resonates with what Winnicott (1960) called the area of normal omnipotence and speaks to the latter’s notion that *there is no such thing as a baby* without a mother. To illustrate Bion’s concept, I will present an example of *realistic projective identification* from a case brought to me in supervision by a candidate in training.

DR A AND CORA

Cora was undergoing intensive fertility treatments, including artificial insemination, when she began analytic therapy twice weekly with Dr A. Almost from the start of the therapy, one could detect Cora’s desire for more contact with her therapist, not only in material that spoke to the need for ‘more

frequent treatments, necessary to facilitate the conception’ of the baby to whom the patient desired to give life, but also in Dr A’s experience, which appeared to be a derivative of her countertransference. During this initial period in the treatment, Dr A either reported that she often had great difficulty recalling her sense of the sessions long enough to write them up for supervision, or she complained that she did not have enough time to do so. When she could write up an hour or two, she realised that she had not registered the transference significance of her patient’s communications until well after Cora had left the room, which by then was ‘too late’.

With some encouragement, Dr A was eventually able to interpret the patient’s repetitious material, in the context of her own unsettling experience, as an expression of Cora’s need for more sessions so that the analytic couple might be able to conceive of a baby-Cora needing to be brought to life in the mind of her analyst. The patient was quite moved by this line of interpretation and eventually pursued a more direct request for two additional hours per week.

During the next several months of the treatment, there was evidence in the patient’s material that she experienced herself and Dr A as ‘growing more and more compatible with one another’. The material also revealed Cora’s sense that Dr A was becoming gradually more ‘able to conceive’ of the baby in the patient. Indeed, my supervisee felt, during this time, that she could formulate and transmit, in a more timely way, some rudimentary understanding of her patient’s most primitive fears.¹

¹Winnicott (1958), Bick (1968) and Tustin (1986) each recorded references, both verbal and non-verbal, to certain primitive fears that date back to the earliest state of unintegration as these appear in both adult and child patients. These primitive fears are the terrors of non-being, of falling forever, dissolving in liquid, evaporating in air, spilling out uncontrollably, leaking everywhere, all without any possibility of recovery. These fears are thought to be connected to a traumatic awareness of bodily separateness from the mother before a psychic apparatus has developed sufficiently to tolerate and transform them. Tustin referred to the aberrant behaviours of children who were born with certain pervasive developmental disorders as ‘prenatal aversion reactions’ (1990). She cited clinical material that seemed to demonstrate how some children have suffered disturbances in utero and so are born prone to these disorders from birth (1986). Since the psycho-physical existence of the foetus and mother are still

However, Cora's dread of the weekend breaks appeared to increase in direct proportion to her experience of being understood by her therapist, which led to an increase in Cora's dependence upon her. This extreme dread began to take its toll on Dr A's capacity to tolerate and contain such intense separation anxieties. For example, this dread was expressed in one Thursday hour, the last session of the week, when Cora came in and spoke directly of how relieved she had felt by the end of the previous hour, although her voice was flat as she reported this improvement. Following a long silence, she added that she had felt 'still' all morning long while awaiting the time of her session.

Dr A was at a loss to understand this mixed communication and became quite anxious as Cora went on to say that she was wondering if, in the previous hour, she had been accurate in her perception that Dr A had tears in her eyes. She further explained that she recalled feeling touched when these tears appeared, as it meant to her that Dr A might really be willing and able to feel something of what Cora was going through. However, the patient was also disturbed when this positive feeling was suddenly followed by an awful thought: that the tears were merely a part of the therapist's technique. With no immediate response coming from Dr A, Cora emphasised that she really needed to know if the tears were real or an aspect of technique.

As Dr A remained silent Cora reiterated, with some urgency, that she thought it important for her to know whether or not her initial perception regarding the tears was correct. However, while feeling under extreme pressure to say something, Dr A could not make head or tail of her patient's material. At this point, Cora's tone changed to one of despair, followed by an air of icy indifference as she announced that she was

aware that even if Dr A could bring herself to confirm the genuineness of the tears, she probably would not believe her anyway.

As Dr A remained unresponsive, Cora went on (as if to change the subject) mentioning that she was having qualms about the week's fertility work. She had undergone three inseminations so far that week and, although she had been more hopeful than usual after Wednesday's procedure, she now felt doomed, afraid that, like all the other times, the embryo had failed to implant itself in the womb and she would surely begin her menstrual period, with the little embryo sloughing off, draining away into nothing; she said, 'It's such a pity, so much money, so much pain and hard work flushed down the toilet like nothing'.

By now Dr A could feel her patient slipping away and she grew desperate to give Cora something to hold on to. She thought about the up-coming weekend and decided to take up Cora's questions as the patient's way of making herself 'still' and deadening her feelings about the break by rendering the analyst's interventions over the previous three sessions inconsequential. She suggested that Cora was 'sloughing off' or 'flushing' them down the toilet like so much waste, and went on to point out to her how this 'wasting of the analytic week' left the patient in a state of despair, which was then covered over with an air of icy indifference.

Cora quickly reacted to this line of interpretation with overt rage, telling Dr A that she couldn't really speak about what she was feeling about the 'damned weekend'. She could only say that she was growing less and less certain that the therapist would be there for her by Monday. Then she added, 'In fact, *I'm not even sure that I will be here on Monday*'.

Clearly frustrated, Cora now demanded

interwoven during pregnancy or around delivery, any trauma to the mother resulting in extremes of depression or anxiety has an impact on the child's psychic development and sense of ongoing security even before birth. Without going into the details of Cora's pre-natal history, discovered at a late stage in the analysis, suffice it to say that there is evidence that this was so in her case.

even more forcefully to know the answer to her original question. Under still more pressure, Dr A said that she wondered what might lie beneath the patient's question. Understandably, this tactic only served to provoke more frustration in the patient. She replied defensively that she was sure that if she said anything more about why she needed to know the answer or what she herself thought or felt about the question, that she could never be certain that Dr A was answering truthfully about the tears; that she would never know if her therapist was being real or if she 'was just using a technique'. As they were out of time, Dr A ended the session and the patient left in an angry huff, slamming the door of the consulting room loudly behind her.

In our supervisory hour, which took place on Monday shortly before she would see her patient, Dr A reported that after the session she had felt terribly anxious and upset. She simply 'could not get her patient out of [her] mind'. She was afraid that, when Cora said that she was not even sure that she herself would be there on Monday, the patient was planning to break off the treatment. Subsequently, the candidate not only feared that she had lost her patient forever, but she was also left feeling abandoned and at a loss to understand what had gone wrong.

Dr A confided that she had examined these feelings of abandonment in her personal analysis and had found that these were somewhat related to her own analyst's upcoming holiday. However, as this insight afforded Dr A little relief from her anxiety about her patient, she hoped that I could help her to trace what she might have missed with respect to Cora's experience in the Thursday hour.

It seemed to me that in the beginning of

the Thursday hour Cora may have been trying to express how hopeful she had been when it had felt to her that she and Dr A had been able to 'conceive' of the patient and her difficulties in the previous three sessions—just as she had felt hopeful after the three inseminations that week. However, it appeared that Cora was also attempting to let Dr A know, by the tone and shape of her voice, that this hopefulness had begun to flatten out or perhaps that it had begun to wear thin by Thursday morning prior to her session, as she was already beginning to experience the impending weekend as a dangerous discontinuity in their contact.

Here we could see that Cora was not just fearing the future separation from the therapist, but was already actually feeling herself as 'still' or perhaps 'stillborn' in the present. Apparently unable to breast² her analyst's silence, Cora seemed to reach for the memory of the tears she had seen in Dr A's eyes, which she had taken as a sign of emotional contact: proof that Dr A really did exist. Her enquiry may have been an attempt at testing the reality of this perception in the hope of obtaining validation of her sense that Dr A had indeed taken her in throughout the week. However, the wait for some understanding was clearly too long for this patient at this time, and her anxiety proliferated.

To complicate matters, Cora's overflowing fear was clearly more than Dr A could contain, while encumbered with her own as yet unconscious anticipation of loss. Unable to tolerate doubt long enough for intuition to shed light on the evolution of the session, Dr A missed the significance of her own experience of 'her patient slipping away' and her 'desperate need to give Cora something to hold on to'. Instead Dr A grasped for general theory upon which to base her

²The verb 'to breast' was first brought to my attention by Frances Tustin in 1987 and means 'to contend with or to surmount'. I find it of interest that, alongside the usual definition of the noun as an anatomical aspect, with or without function, most dictionaries also carry references to the 'breast' as the seat or heart of all thought and feeling.

interventions. The ensuing all-too-pat interpretations, regarding what she assumed to be Cora's omnipotent denial and denigration of the value of the analytic work, only served to provide confirmation of the patient's sense of 'mis-conception'.

In this example, I believe one can appreciate Cora's attempt to communicate—through *realistic projective identification*—something about the deepest level of her most troublesome state of mind as it was being experienced in the immediacy of the session. While feeling 'sloughed off' waiting for her Thursday hour, she seemed to be prematurely losing the experience of the analyst's containing presence gained in the three preceding hours, which she subsequently feared was 'merely a technique', not unlike the insemination 'technique' that had thus far failed to lead to the conception of the 'baby she wanted so much to give birth to'. I would suggest that Cora was not only experiencing the loss of the mother-analyst, but also the loss of that embryonic self, which had just barely been conceived through the first three sessions of the analytic week.

Without sufficient time in which to build up and firmly establish a consistent and enduring experience of herself safely enclosed in the mental womb of the mother-analyst, a 'containing object' was yet to become securely implanted in Cora's own mind. Thus, Dr A's silences and her 'mis-conception' of Cora's dilemma threatened to abort the beginnings of this internalisation process and Cora began to slip away in the Thursday session. As if in a last ditch attempt to re-establish contact with Dr A, Cora seemed to slam herself into her analyst's mind, just as she had slammed the door to the consulting room. Through her use of such *realistic projective identification*, we can observe how Cora succeeded in making a place for herself during the break, since Dr A truly 'could not get her patient out of [her] mind' all weekend long.

The situation I have just described was eventually resolved, albeit with much effort

on the part of both members of the analytic couple to preserve and expand the meaning of the projection. However, Bion depicted a 'worst case' scenario, wherein a pathological form of projective identification is set in train. If the mother cannot tolerate these projections, the infant is reduced to continue projective identification carried out with increasing force and frequency . . . [that] seems to denude the projection of its penumbra of meaning (1962, p. 182).

He pointed out that, subsequently, the process of reintroduction results in an internal object that strips of its goodness and tentative meaning all that the infant receives and gives, starving its host of any understanding that is made available.

In other words, there are severe long-term consequences for the normal development of thoughts and thinking when there is 'a breakdown of interplay through projective identification between the rudimentary consciousness [of the infant] and maternal reverie' (p. 183). In such cases, 'The tasks that the breakdown in mother's capacity for reverie have left unfinished are imposed on the [baby's] rudimentary consciousness' (p. 183)—which is omniscient and omnipotent by nature—leading to the 'establishment internally of a projective-identification-rejecting-object . . . This means that instead of an understanding internal object, the infant has a wilfully misunderstanding object with which it is identified. Further, its psychic qualities are perceived by a preconscious and fragile consciousness' (p. 184). I have found that oftentimes such an internalised object figures into most unresolvable impasses and may be the product of more than one generation of breakdown in the interplay, through projective identification, between the rudimentary consciousness of the baby and the reverie of the mother.

Bion's model of the 'containing' object helps one to further appreciate the importance of both projective and introjective identification in normal development, and implies that the mother's state of

mind—most of all her capacity to deal with her own as well as her infant’s anxieties—is the fulcrum upon which the baby’s security and thus his mental health pivots. So, in the interest of clarity, I will take a moment to elaborate this concept, as I understand it, and will try to highlight its influence on my analytic technique.

MOTHER AS CONTAINING OBJECT

In his model, the mother—in a state of what Bion called *reverie*—first receives and takes in (or to use the prevailing lingo ‘introjects’) those unbearable aspects of self, objects, affects and unprocessed sensory experiences of her infant that have been projected into her in phantasy.³ Second, she must bear the full affect of these projections upon her mind and body for as long as need be in order to be able to think about and to understand them, a process that Bion referred to as *transformation*. Next, having thus transformed her baby’s experiences in her own mind, she must gradually return them to the infant in detoxified and digestible form and (at such time as these may be of use to him) as demonstrated in her attitude and the way in which she handles him. In analysis, Bion referred to this last process as *publica-*

tion, what we commonly refer to as interpretation.

As one can readily see, the ability to ‘contain’ assumes a mother who has boundaries and sufficient internal space to accommodate her own anxieties as well as those acquired in relation to her infant; a mother who has a well-developed capacity to bear pain, to contemplate, to think and to convey what she thinks *in a way that is meaningful to her infant*. A mother who is herself separate, intact, receptive, capable of reverie and appropriately giving is thus suitable for introjection as a ‘containing’ object, and, little by little, over time, the infant’s identification with and assimilation of such an object leads to increasing mental space, the development of a capacity to make meaning (what Bion called *alpha-function*), and the ongoing evolution of a mind that can think for itself. Should such a description seem idealised, I would suggest that it corresponds to Winnicott’s (1960) *ordinary devoted mother* in his model of mental health.

I believe that Bion’s use of the term *reverie*—for the attentive, receptive, introjecting and experiencing aspect of the container—refers also to the function on the part of the analyst that is analogous to what I call *taking the transference* (Mitrani, 1999).⁴ To

³It may be important to underscore that the process of ‘reverie’ consists of both conscious and unconscious elements.

⁴In her psychoanalytic work with children, Melanie Klein not only observed the ‘child’s play’ as the equivalent of the adult’s ‘free associations’ but, perhaps most importantly, she went along as much as was feasible with the various roles assigned to her by the child patients she treated. She made inferences derived from this ‘play’ and interpretively addressed the underlying phantasies and deepest unconscious anxieties expressed in it. When addressed openly by the analyst with respect and seriousness, these anxieties were gradually modified. Additionally such interpretations, rather than shutting off the production of these phantasies, encouraged and facilitated their proliferation. Klein was surprised at the richness and complexity of the unconscious phantasy life of the very young child in relation to his objects, including elements of violence and destructiveness as well as curiosity and profound love. Klein’s development of the play therapy technique led to modifications in the analytic work with adults as well. For example, *the free associations of adults came to be seen as equivalent to the play of children*, and as such they can be appreciated not just as communications that inform the analyst, but also as *actions that clearly have an effect upon the analyst*. The significance of the consulting room and everything in it, as well as the personal idiosyncrasies of the analyst, are a part of the adult ‘play space’ and the act of *taking the transference* might be seen as analogous to Klein’s policy of going along with the roles assigned to her by the child patients she analysed. The unconscious process of identification that may follow leads to what Bion called ‘learning from experience’.

my way of thinking, the act of *taking the transference* is a necessary and indispensable step on the way towards the interpretation of the transference, especially when dealing with primitive mental states.

The inability on the part of the analyst to 'take' the patient's material in the transference and its consequences can perhaps be readily traced in the following example from a case presented to me, with much candour, by a colleague in Israel who wished to learn how the way in which she worked might have contributed to a premature interruption in this analysis. The reader may note, in this example, a marked difference between Dr A, who was able to 'take the transference' but who did not quite know what to do with it (like a mother who is capable of 'reverie' but whose capacity for transformation is deficient or as yet undeveloped), and Dr B whose capacity for reverie seems to have been obstructed.

DR B AND GAILA

Dr B presented material from one of the last sessions with Gaila, a female patient near her own age. It may be important to note that both analyst and analysand shared a similar history as children of Holocaust survivors. Gaila returned, after a weekend break in the second year of treatment, complaining that she had not been able to sleep since their last session. She then reported that X (a friend) had told her about a conference held in a fashionable resort where she had heard Dr B and her husband presenting. Gaila said that X had commented on 'what a handsome couple they made, so well suited to each other'. Gaila then mentioned another friend, Y, who had miscarried her baby over the weekend. She criticised Y for smoking during the pregnancy and felt strongly that Y had clearly not taken into consideration the effects of this dangerous behaviour upon her foetus. Gaila said that she thought that Y did not really wish to have a baby, as she seemed to be

much more interested in her successful career and in continuing a carefree lifestyle with her husband.

Dr B took up this material as the expression of an 'old hurt' stemming from Gaila's childhood experience of her mother who had been negligent and irresponsible, smoking during her entire childhood, which made her mother seem negligent and disinterested, and left Gaila feeling that she had been 'miscarried' and therefore unloved by a mother who did not want her. The patient responded to this interpretation with the telling of a dream: *she was in a hospital and the doctor attending her bedside was not taking her complaints to heart. Gaila thought in the dream that the doctor might think she had something contagious and was thus keeping some distance from her and so was having difficulty diagnosing the problem. The patient knew she had a brain tumour as a result of some shrapnel embedded in her head when it had ricocheted off the chest of another soldier. She thought how unfair it was since it was not her war, but rather belonged to the dispute between older generations. No one took responsibility for the conflict and she was fearful that she was going to die as a result.*

It appeared that Dr B had overlooked the possibility that Gaila might have been making reference to her sense that the analyst chose to resume her career and her carefree life with her husband over the weekend break, leaving Gaila feeling unwanted and aborted. In this context, the dream seemed to suggest that the genetic interpretations made by the analyst may have left the patient feeling further pushed away and was contributing to the doctor's difficulty in understanding her dilemma, which was linked to the older generation who could not take responsibility for their own experience, instead passing this on (perhaps through projective identification) to the younger generation.

Dr B had thought at the time that she was being empathic when she took up the dream

as an expression of Gaila's experience of being made to suffer due to *her mother's* lack of responsibility and from the aftermath of the war, especially the Holocaust, which belonged to *her mother's* generation and not to her own. The analyst was unable to imagine that the patient might have been attempting to call her attention to the miscarriage that was occurring in the analysis at that very moment, the sense that the analyst-mother was deflecting the transference, including the patient's sense of being dropped and therefore mortally wounded.

As one often observes when misunderstandings occur, the patient was unresponsive and nothing Dr B could subsequently say served to reach her. Gaila remained mute until finally she said: I've been thinking of changing jobs. My employer treats me unfairly. She goes over my work and when I get it back, it's such a mess, it's unrecognisable. She always blames me for everything that goes wrong. It doesn't matter what I do. I try to take responsibility to put things right again, but she never considers her part, and I feel hurt and resentful. I've been sick more often on this job than any other. I feel trapped. It's a bad job. I know I can leave, but where would I go? I'm unqualified for other work'.

Painfully, Dr B continued to address how trapped Gaila felt with the mother she was born to—that she could not bring herself to leave her mother, and the various effects upon her of Mother's Holocaust experiences—while the patient continued to fall deeper and deeper into despair, silent through to the end of the hour. This pattern is one that is frequently found in the sort of impasse where the unifying thread is a *coincidence of vulnerability between analyst and analysand*, resulting in a kind of *transference blindness*. In the case of Dr B and her patient Gaila, their shared vulnerability was stimulated but not responded to, as both members of the therapeutic couple were trapped in the same post-traumatic experience (the Holocaust like the 'bad job'), unable to find refuge from

the psychic shrapnel that may have bounced off the protective shielding of their respective parents (the other soldier), with each suffering the trauma that rightfully belonged to 'another generation'. The patient had attempted once again to reach the analyst when she spoke of the 'bad job' and the 'blaming employer' who did not take responsibility. However, in the absence of one who could contend with the pain and frustration, Gaila retreated into silence.

In the transference enactment of this situation, the analyst (as the doctor in the dream) was felt not to be taking the patient's complaints to heart (that is, she did not take up the complaint as an indication of how the patient may have felt about her analyst). The resulting silence may have been an indication of the death or deadening of that communicative aspect of the patient. Here we can see that what Dr B interpreted was the content of Gaila's material and the link to the genetic situation (in the past), while the essential experience of her analysand in the here and now of the negative transference was bypassed rather than taken in, resulting in a repetition of the original trauma: that of being in the care of a mother who, while filled with her own unbearable and undigested suffering, was unable to bear feeling her baby's suffering in relationship to her own human failings.

The primitive, infantile, *unmentalised experiences* (Mitrani, 1995) of helplessness, terror and loss, when reactivated by the Holocaust experience, often prove so horrific for some that much of their emotional charge has been foreclosed from the mind of the parent, and later the analyst, in the service of survival. In the case of Gaila and Dr B, just as the analyst had unwittingly abandoned the transference in the interest of her own psychic survival, so did the analysand eventually abandon the analysis, disillusioned and hopeless about her 'qualifications for other work'.

As one can see, the act of *taking the transference* does not merely entail a

cognitive understanding of or an empathic attunement with what the patient is feeling towards and experiencing with the analyst in any given moment. It also refers to the introjection by the analyst of certain aspects of the patient's inner world and experience, and a resonance with those elements of the analyst's own inner world and experience, such that the latter is able to feel herself to actually be that unwanted part of the patient's self or that unbearable object that has previously been introjectively identified with.

This may be one of the most difficult aspects of our task, as it is not a matter of goodwill or adequate training, but an unconscious act governed by unconscious factors in response to an emotional experience. Bion considered the *emotional experience* to be the only 'fact' (1976/1987, p. 242) or true evidence upon which we may reliably base our interpretive interventions. Two brief examples of what I'm trying to highlight might be helpful here, the first from my work with Hendrick, whom I have written about extensively in another context (Mitrani, 1999).

HENDRICK

A markedly depressed and angry man in his late forties, Hendrick was referred to me for analysis many years ago. On first meeting, I found him standing up in my waiting room, a physically imposing, raw-boned, 6ft 6in man. After introducing himself to me, he lumbered into my consulting room with an air of menace and sat, stoop-shouldered and sullen, inspecting the premises with suspicion. His expression was brooding and, although his posture was slumped as he sat in the chair, he appeared ready for combat, fists clenched and eyes scanning my room as if for an opponent.

However, in contrast to his impermeable countenance, I was surprised as Hendrick poignantly confessed to feelings of extreme loneliness and isolation in his personal life.

He confided that he was on the verge of being dismissed from his position for belligerent behaviour towards female co-workers, many of whom he had reduced to tears on more than one occasion. He was seeking help, fearing that he might be labelled 'unemployable' if he could not learn to control his interactions with his fellow workers, which he characterised as 'bullying and intimidating'.

The patient also disclosed that he'd never been able to consummate a sexual relationship with either a woman or a man, although he reported that he had lived with one woman for a brief period some twenty years before. He said that although they had slept together in the same bed, 'there was no intercourse'. After this relationship ended, Hendrick had spent nearly all his weekends engaged in anonymous sex-play with 'parts of people' through 'glory holes' in public restrooms and lurked on the periphery of school playgrounds with fantasies of dominating young boys. Although he had never even come close to acting out these fantasies, he damned himself as a paedophile. I understood this behaviour to be an expression of Hendrick's need to distance himself from the pain of longing for wholesome relationships that seemed out of his reach and his need to gain dominance, if only in phantasy, over those vulnerable aspects of his child-self.

What is of interest here to our discussion of *taking the transference* is something that occurred at the end of this initial interview when Hendrick stood over the chair in which I sat and extended his hand in such a way that I felt he was both challenging me to shake it and daring me not to. In that instant, I sensed that either way I would be faulted and condemned to death! In spite of the fact that I desperately wanted to find some hole in the floor to crawl into, I responded by taking his hand in mine.

As I did so, I suddenly felt terribly small, frightened, helpless, vulnerable and, yes, 'bullied and intimidated'. The remainder of that week was no less disturbing for me, as

Hendrick repeatedly cursed at me in a booming baritone voice about everything from my physical appearance, to the layout of my room, my 'reserve' and the fees he had agreed to pay me. Although I could well understand why several other analysts had refused to take him on, I also was struck by and greatly appreciated what I considered to be Hendrick's unconscious co-operativeness and his true capacity for communicating his most primitive experiences to me.

When I recovered my wits long enough to think about my experience of these events, I was convinced that Hendrick was unconsciously attempting to get across to me some sense of what it was like to be a very little child, perhaps under threat of abandonment by a mother-me on whom he depended for survival and especially his need to take cover from that threat. Taking this up directly in terms of our connection—his unbearably painful and humiliating need for me to help him, his unthinkable fear that I would reject him *out of hand*, as well as his inclination to hide his vulnerability from me within a cloud of intimidation—proved quite relieving to this man and eventually led to the recovery of his earliest memories of his mother.

Mother had fallen gravely ill when Hendrick was less than a year old, subsequent to the birth of a second child who was congenitally impaired and who eventually died. I was later to hear about what I could only intuit at first: that Mother's 'sickness' was characterised by frequent and violent fits of rage, which erupted in verbal assaults aimed at a little Hendrick, and culminated in bouts of vomiting and vegetative depression. One can see in the case of this analysand how 'the tasks that the breakdown in Mother's capacity for reverie [had] left unfinished'—the transformation of Hendrick's infantile experience—had been 'imposed on the infant's rudimentary consciousness', omniscient and omnipotent by nature. Thus a little-Hendrick was compelled to toughen up in order to withstand both his as well as his mother's fears of death, as her own uncontained and

unbearable grief and rage overflowed into her young son.

Yet another example of what I am attempting to get across can be found in the first hours with a patient I call Anthony.

ANTHONY

An attractive and highly articulate man in his mid-thirties, Anthony was referred by a colleague from another state. It was clear from the initial phone contact that he had not previously sought therapy. During the course of our first two meetings, which took place on a Monday and Thursday of the same week, Anthony sat quite relaxed in a chair and he calmly and matter-of-factly presented a very organised history of his 'very ordinary' early childhood, education and career, as well as a description of his relationships to date. From his description of them, Anthony's parents seemed unremarkable, ordinary and certainly 'good-enough'.

However, on another level, there was an undercurrent of deadness, deep despair and aloneness in spite of what *seemed* from Anthony's lucid narrative to be an uneventful childhood and college experience and some satisfactory if not intimate or close relationships with both male and female friends. I sensed that there was some aspect of Anthony's situation that we had not yet arrived at in these two meetings, something that he was helpless to know and to tell me about in any direct way. This feeling was especially strong in me at moments when there would be a pause in his otherwise smooth recital. During these pauses, Anthony seemed to focus his gaze on my couch, positioned to my right, against the wall opposite the chair in which he sat.

Frequently, as I listened to Anthony, I felt extraneous, unnecessary and unwanted. At other times, seemingly unrelated to the content of what he was saying, I became quite agitated and felt increasingly empty-headed, this especially towards the end of the second

hour. I feared that had I been able to think of something worth saying, there would be little room for me to insert myself. In contrast, Anthony appeared nearly emotionless and untouched. He approached the end of each of the interviews right where he had begun: with a simple statement that he ‘wanted to see a therapist because there was something that did not feel quite right’.

I considered the possibility that Anthony was unconsciously ‘sharing’ with me a portion of his own feelings of inadequacy and self-doubt to such a degree that I could barely function. I was aware that I had been quite inactive during these first meetings, which is not customary for me even with new patients. Further considerations brought to mind two things: first, I imagined that Anthony might be expressing a desire to ‘see’ me—the therapist—to get a glimpse of what I was like. Perhaps what ‘did not feel quite right’ was my silence, experienced as an absence of the therapist he needed to see.

Second, I wondered if he might be ‘telling me’ about his experience of a mother who had been—in some ways—‘unseen’ or absent-minded, although this did not seem to fit his earlier description of either the mother or father of his childhood. I finally offered aloud that he might be letting me know that, although he wished to continue with me for now, he did not find me very comforting or present, perhaps not quite right for him. On hearing this, he smiled at me for the first time, in a boyish way seemingly pleased that I had noticed that he was not mad about me, that I would take the responsibility for bringing this up, and that I did not seem to be put off by his lukewarm reception of me.

In response to my interpretation, Anthony said that he now felt oddly more comfortable with me than he had been feeling and did indeed wish to make another appointment for the following week, although he didn’t know just what we might accomplish together.

To my surprise, in our very next meeting, he reported the following dream: *he is seated in a room when he suddenly notices that he is*

not alone, that there is a tiny baby in the room with him. He realises that he is supposed to be watching over this baby as it lies in its crib, but he immediately senses that there is something wrong and begins to feel anxious. He notices that the two sides of the crib have either been left down or are missing altogether. Only the two ends are in place. He also notices that the baby’s head is not supported and it seems uncomfortable for him. In the dream he thinks that the baby needs a pillow or a cushion, but wonders at the same time if very little babies can suffocate with a cushion.

He looks across the room from where he sits and sees a pillow on a couch, but feels suddenly paralysed—unable to move to reach it. His arms and legs are weak and unsteady and he knows he needs help, perhaps to pull up the sides of the crib so the baby won’t fall out. He notices an older woman sitting in a black leather chair, not far from him. He has a thought that she might be able to help, but is unsure that she would want to. He thinks: She would need to carry me over to put the sides up, but what if she doesn’t want to, or perhaps she can’t. He feels hesitant at first to ask the woman for help. Finally, he calls out, but she can’t hear him. He wakes up frustrated and crying.

After a pause, Anthony said that he didn’t know what the dream meant. He certainly didn’t have much experience with babies! Next, he said that the black chair in the dream was something like the one that I was sitting in. Once again he paused and looked away from me and directly at my couch. He said, ‘You know, that’s an odd piece of furniture! It looks like a cot, not like a couch at all’. He noticed that there were no cushions at the back, only at one end, and he asked if people really lay down on ‘those things’.

I told Anthony that it seemed that, as in the dream, there might be a baby—he who needed watching over, a little one who suddenly appeared after our meetings last week, a baby I had carelessly left him alone to mind since our last meeting. I added that I thought that

perhaps he'd been worrying that this baby was in danger of falling, with only the ends of the crib—like the ends of the last week—in place.

With eyes wide, brows arched and an upward curve to his mouth, Anthony seemed both surprised and interested in what I was saying to him. Thus I continued, wondering aloud if he might now be expressing a wish to ask for my help to secure the baby—he with two more hours per week as a way of supporting his developing mind and giving him both a sense of comfort and a feeling of safety. Perhaps he was also letting me know of his concern that I *could* not or *would* not be able to carry him over, and was also somewhat afraid that so much contact between us, like a cushion in the crib, might be too suffocating.

Anthony responded sheepishly, confirming that he had indeed been wondering, over the days since our last meeting, if anyone ever came to see me that often. Then he'd had the thought that he might not be able to afford to come more frequently and that I probably wouldn't agree to adjust my fee to accommodate him. He had also had the urge—many times during our sessions in the previous week—to lie down on the couch, and he tried to imagine what it would feel like if he did, although it had seemed too scary then even to enquire about it. I replied that I wondered if *perhaps I had seemed too scary* to approach.

After a pause Anthony said that, as I was speaking, he remembered something he'd neglected to mention. He caught me completely off guard as he told me that, as a baby, he'd been adopted. In his early teens he had been informed by his adoptive parents that his birth parents had been very young and too poor to keep him. Thus, they had given him up at birth. He thought it strange and was feeling sad that he had not given this much thought over the years until now. It just 'was what it was', and did not strike him as significant. It hadn't mattered.

Returning to the dream, I told Anthony

that perhaps the missing birth parents were like the sides of the crib that were missing. Perhaps he might also be telling me, by way of the dream, that we needed all four sides—four hours per week on the 'cot' with the pillow—so that he could feel safe with and comforted by me while he gave thought to these childhood losses, even though it was clear that we would need to be mindful of a baby—he who might be in danger of being overwhelmed, both by such close contact with me, and also by his feelings about what he had missed long ago and was more recently experiencing missing.

This example may demonstrate how material presented in the very beginning of the treatment is not just a repetition of old attitudes, events and traumas from the past, but how it is alive in and can readily be taken up in the 'here and now' of the transference; how this works to mobilise additional unconscious material, phantasies and memories while establishing a closer connection between analyst and patient, thus affording the patient an experience of the analyst's presence and way of working as well as her willingness to contend with a burden the patient has felt unable to bear on his own. One can also notice how anxiety-ridden issues of frequency of sessions and the use of the couch might be heard in the patient's material and addressed early on in the work, even before the patient can dare to hear or know or want in relation to the analyst.

Once again we can see how, without adequate transformation of his early situation, Anthony had become insensitive to ('it was what it was') and did 'not have much experience with' his own baby-self in favour of surviving what may have been both his birth parents' as well as his own uncontained, unbearable and therefore unwanted beginnings. Not unlike Hendrick, the earliest happenings in Anthony's life had been left to the devices of his 'rudimentary consciousness'.

While working with patients such as Hendrick and Anthony, one is struck by how essential it is to resist the pull towards

reliance upon memory of theories or to be influenced by the desire to give a patient something when we are faced with doubt and uncertainty. The transference must be taken and the emotional experience had and tolerated by the analyst in order for her to make optimal use of such realistic projective identification. This brings me to Bion's recommendation that we attempt to work without memory and desire. I will address this curious and often misunderstood notion of Bion's and what I believe to be its main technical implications.

ONEVIDENCE, MEMORY AND DESIRE

In one of his most controversial papers, 'Notes on memory and desire', Bion gave me food for thought regarding issues of technique in analysis. In this compact communication, not much more than a thousand words, Bion made a plea for the analyst to eschew memory and desire deriving from sensuous impressions of 'what is supposed to have happened' (1967/1988, p. 17) and of 'what has not yet happened' (p. 17), in favour of the reliance upon an emotional experience or 'feelings', which he designated as the only 'facts' we analysts have upon which to base our interpretations.

Bion further argued that memory is misleading as it is always distorted by unconscious processes, and desire interferes with the capacity to observe, which is essential to sound judgement. In support of a technique utilising here-and-now interpretation, Bion stated that, 'Psychoanalytic observation is concerned neither with what has happened, nor what is going to happen, but with what *is* happening' (p. 17). Both Cora and Gaila may serve as reminders of the need for attention to this way of working. It is perhaps essential to note that Bion encouraged the analyst's at-oneness with her intuition, insisting that what is already known is obsolete. Only the unknown is relevant and 'Nothing must be

allowed to distract [us] from intuiting that' (pp. 17–18).

Next, in what may be the centrepiece of this paper, Bion wrote:

In any session, evolution takes place. Out of the darkness and formlessness something evolves. That evolution can bear a superficial resemblance to memory, but once it has been experienced it can never be confounded with memory. It shares with dreams the quality of being wholly present or unaccountably and suddenly absent. This evolution is what the analyst must be ready to interpret (p. 18).

Bion cautioned that when memory and desire occupy the mind of the analyst, this evolution is missed while it is taking place. He acknowledged that adherence to this 'rule' would certainly lead to increasing anxiety for the analyst; anxiety that accompanies a state of experiencing and of 'not knowing' on the way towards intuiting evolution. However, he assured us that the pay-off will come with signs of progress in each meeting, where the tempo of each and every session quickens, the 'number and variety of moods, ideas and attitudes' (p. 18) increases, and the repetition in the material decreases. Additionally, Bion promised that the analyst's interpretations would 'gain in force and conviction—both for himself and for his patient' (p. 19)—when these are derived from emotional experience with a unique individual rather than from generalised theory.

Since Bion suggested that the technical implications of his rules 'can be worked out by each analyst for himself' (p. 19), I will share my thoughts on the subject and hope to stimulate discussion. First, it is my understanding that Bion uses the term 'evolution' to indicate a situation in which some idea or pictogram is evoked, floating unbidden into the mind of the analyst in response to the words and music of a given session. Inspired by the writings of the poet, Bion seems to be suggesting that an 'irritable reaching after fact' or a practice of 'forced recall' shall be relinquished in favour of the disciplined yet

fluid state of mind that Keats (1817/1973) referred to as ‘negative capability’.⁵

Bion also seems to be arguing the point that memory that is forced is the past tense of desire, while anticipation is its future tense. Both distract us from the present emotional experience, and this I believe is the crux of the matter if one feels, as I do, that what we hope to achieve is a state of being with the patient in the present so that he/she can eventually bear to be him/herself, with him/herself. So how does this impact our technique in psychoanalysis? Towards answering that question for myself, I was once again put in mind of some of Bion’s seemingly peripheral remarks in his paper on ‘Evidence’ regarding the ‘publication’ of the analyst’s emotional experience. In that paper, Bion asks the question: ‘What are we to say to people who are not psycho-analysts, or have not had psychoanalytic training, or, for that matter, if they have? . . . to communicate [my emotional experience] to somebody “not me”’ (1976/1987, p. 240). Here Bion seems to be asking us to consider our style of interpretation, which needs to be free of cliché or jargon, down to earth, immediate and accessible, especially to the infantile aspects of the patient, and evocative in the here and now in order to facilitate a genuine connection.

I think that Bion’s idea of ‘eschewing memory and desire’ implies that when the analyst offers *genetic interpretations or even interpretations of the patient’s analytic past* (in other words, what the analyst has learned about the patient in past sessions or from the patient’s own narrative history) he/she is relying on memory (his/her own or that of the patient or perhaps even others in the

patient’s sphere of influence) rather than the analyst’s own intuitive observation of the present situation and of the patient who is present in the room. In such instances, the analyst runs the risk of colluding with that part of the patient that strives to conserve the *status quo* and therefore to impede evolution.

Similarly, if the analyst offers interpretations *about what the patient fears will happen or hopes to have happen in the future*, the analyst may miss an evolving terror or a longing stimulated by contact with him/herself, or perhaps even a fleeting experience of satisfaction expressed in the moment: something that is felt to be occurring in the presence of the analyst, rather than what may happen during his/her future absences. I find that when I can be with the patient while he/she is experiencing me as either ‘bad’ or ‘good’, then I may have the opportunity to provide him/her with an experience of a containing object for each of these situations. I also might think—while out of the consulting room—about how my patient and I might work together to foster realistic projective identification; how to best offer myself as a processing plant for unbearable feelings and happenings; and how to further facilitate the patient’s introjection of objects that can perform what Bion referred to as the *alpha function*.

I find that, in order to understand the infantile aspects of my patients, I need to be both willing and able to feel like a baby. Of course, one might think that—since we have all been babies—this experience would be well within our emotional grasp. However, I am frequently reminded of how tempting it can be to use my adult experi-

⁵Keats wrote, in a letter to his brothers George and Thomas, that while walking with a friend, ‘several things dovetailed in my mind, and at once it struck me what quality went to form a man of achievement especially in literature and which Shakespeare possessed so enormously—I mean *Negative Capability*, that is when man is capable of being in uncertainty, mysteries, and doubts, without any irritable reaching after fact and reason . . . capable of remaining content with half knowledge’ (1817/1973, pp. 477–8). This passage from Keats’s letter seems to have resonated with Bion’s own attitude or perhaps it had an influence upon it. In either case, the notion of *negative capability* became central in Bion’s analytic work and especially in his later writings.

ence and competence, my training and especially my 'favourite' theories to avoid *feeling* the vulnerability and sensitivity of the infant and young child whenever I can. Unfortunately, this may lead to misunderstanding the patient through interpretations that lack contact (on all but an intellectual level) with certain elemental terrors and longings that even a psychoanalyst would rather overlook.

Sometimes it may be far less distressing to address the current situation of the patient's life outside the immediate transference happening, his/her childhood history or even the dynamics of his/her internal world. However, in turning my interpretive attention to current events outside the consulting room or towards the historical past, I may be (often accurately) perceived as distancing myself from certain infantile aspects of my patient. In like manner, I may be felt to be altogether abandoning the infant-in-the-patient if I fall into an intellectual discussion with an often precociously adultified patient, about his/her internal conflicts. As sterile as it may become, I find that this sort of academic engagement is often quite well tolerated by candidates in training.

Additionally, although it can be somewhat disconcerting when a patient does not accept whatever he/she is given, at such times I might need to consider the possibility that what the patient cannot or will not take in may truly be indigestible for him/her. I might even need to conceive of a situation in which, in spite of my desires for it to be otherwise, a mouth through which to feed or a stomach in which to hold food has not yet formed in the patient's mentality. At such times I may need to take great pains to detect and to describe this in some way that is meaningful to the patient, while refraining from accusations and explanations that may only serve to heighten the domination of his/her 'rudimentary consciousness'.

In other words, I may need to stretch beyond what is 'known' in order to encompass what is immediate for the patient at any

given moment and to maintain contact, in spite of the distractions, with those elements of the patient that are most in need of my help: those vulnerable, embryonic, foetal and early infantile aspects that have not yet had the experience of being 'conceived' in the mind of another and are not as yet fully formed. Without such an experience, those primordial happenings that have been necessarily foreclosed from awareness will remain unmitigated, unable to be borne in the mind of the patient, which itself has not had sufficient opportunities to settle in, to take root and develop.

I believe that one key to such development of 'mind' is Bion's concept of the 'containing function' of the analyst, which needs to be experienced, consistently over a lengthy period of time. Technically speaking, the gradual introjection of (or introjective identification with) the analyst—in the act of receiving, processing and making meaning of the raw sensory experiences of the patient—may best be achieved through direct, immediate and clear interpretation of the transference as it is *experienced from the patient's point of view*. I am convinced that contact made in this way offers the patient a sense of being in touch with an emotionally and mentally available and a firm-but-not-rigid bounding presence capable of introjective identification.

When the analyst accurately intuits the patient's 'vertex' or point of reference, he/she may be able to compose what I have come to call an *introjective interpretation*; that is, one based upon an act of *introjective identification*. As I have demonstrated in the cases of Hendrick and Anthony, this kind of interpretation often culminates in an experience of 'being understood'. In contrast to this, when the analyst formulates interpretations based upon his/her vertex—in other words, his/her own sense of the patient and of what he/she believes he/she is 'doing' to him/her in phantasy through his/her various defensive manoeuvres—this constitutes a *projective interpretation* wherein the analyst

returns that which had been projected into him/her by the patient.⁶ It has occurred to me that this type of interpretation is, in and of itself, an act of projection on the part of the analyst, albeit aimed towards helping the patient to 'have understanding' or to 'gain insight' into him/herself. However, the use of this variety of interpretation assumes that the analysand has developed adequate mental space in which to house self-awareness, as well as sufficient ego strength to contend with experiences of separateness. By their very nature, projective interpretations are 'weaning' interpretations that require a firmly rooted bonding background.

Arguably, the kind of interpretation that addresses the patient's projections may sometimes be helpful to him/her, even when the inception of a containing object and a space for thinking is tenuous and rudimentary, if such projections are sincerely perceived and understood by the analyst as a part of the patient's attempt to communicate. In other words, the earliest insight or 'core' insight—like the 'good' object at the core of the ego—must be some 'good' aspect of the self. This particular subset of 'projective interpretation' can further strengthen the positive libidinal tendencies in the patient and may foster his/her faith in his/her own inner goodness, which mitigates the potential for envy. Like the 'introjective interpretation', this sub-category of the 'projective interpretation' may also increase the patient's experience of the analyst's goodness, that is, his/her capacity to receive and to make sense of his/her communications. Thus, the patient may begin to take the analyst in as an object capable of understanding in relation to a

subject or self that is capable of communicating and being understood.

These modes of interpretation, eventually leading to an experience of 'being understood', may also provide an 'object lesson' for introjective processes and may eventuate in a positive build-up rather than a negative depletion of the internal world. In other words, along with an experience of being understood, an object capable of tolerance and understanding is established in the patient's psyche through this kind of interpretive work. The installation of such 'understanding objects' lays the foundation for even more sophisticated capabilities, such as the aspiration and empathy necessary for the patient to understand him/herself as well as others.

As this crucial point in mental development is approximated, both the genetic reconstructions and intrapsychic formulations that constitute further subsets of the 'projective' variety of interpretation may have a truly productive place in the analysis. At this juncture, they can and will be received (more often than not) with interest and even appreciation. Additionally, once the patient has developed some 'presence of mind', these more advanced lines of thinking, stemming from a benign self- and other-consciousness, will likely be brought into play in a non-defensive and heartfelt manner by the patient himself, where previously it may have only been possible to 'play' these constellations out in relation to the analyst or to articulate them in a manner that resembles echolalia.

It may be important to clarify here that I am not necessarily describing stages or

⁶I wish to acknowledge the contribution of John Steiner (1994) who highlighted the differences between what he termed 'analyst-centered' and 'patient-centered' interpretations. Steiner discussed how the former provides the 'containment' necessary for a patient operating predominantly in the paranoid-schizoid position and who thus cannot bear being confronted by the analyst's perspective, which is felt to be intrusive and leads to increased defensiveness on the part of the patient. My notion of 'introjective and projective interpretations' places emphasis squarely upon the analyst's own unconscious processes and takes into consideration how these may impact the development of the patient's mental capacities. Both Steiner's model and my own address the importance of affording the patient an experience of being understood as a forerunner of the capacity for insight.

phases of linear development. Instead, what I am suggesting is that there are cycles that can be detected within a given session or a particular segment of an analysis, related to the working through of certain pathological constellations or states of mind, and leading into the development of the capacity to experience and to think about specific situations as they arise.

In concluding, I wish to express my belief that many of us are drawn to the work of analysis, at least in part, by the desire to do some good. However, paradoxically, this may be the greatest obstacle to actually doing 'good analytic work' and therefore the greatest barrier to truly helping the patient. If unbridled, it may prove to be the most obstructive 'desire'—in Bion's sense of the word—since our patients may actually need to transform us, in the safety of the transference relationship, into the 'bad' object that does harm. In terms of analytic technique, the analyst needs to be able to muster the wherewithal to see, hear, smell, feel and taste things from the vantage point of the patient. I have found it is of little use to give the patient the impression, in one way or another, that what he/she made of what I said or did was neither what I intended nor what I actually did or said. This tactic almost always misses the point and may even reinforce the patient's sense that his/her experiences are indeed unbearable.

Our analysands' developmental need to house their 'bad' objects and unendurable experiences in us is primary. Within us, these objects and the experiences that have created them may find an opportunity for rehabilitation and transformation. For example, the experience of the 'abandoning object' that we become—during holidays, weekend breaks, silences and *especially in the absence of our understanding in the analytic hour*—may have the chance to become an experience of 'an abandoning object who takes responsibility for having abandoned the patient' and who, at the same time, is able to keep the patient in mind sufficiently to be

able to think about how he/she might feel about having been abandoned. Most importantly, that same object may also be experienced by the patient as able to bear being 'bad', which in itself is 'good'! Furthermore, when reintroduced by the patient in this modified form, the 'bad' object is not so 'bad' at all: it is human, ordinary, with all the ordinary human frailties imaginable, but it is bearable. In this transformed state, the 'bad' object (which is now the contained) is enhanced with a 'container' (the analytic object), and the patient will be well on his way towards 'being' a thinking and feeling individual.

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TRANSLATIONS OF SUMMARY

Dans cet article clinique, l'auteur présente un modèle cohérent pour la conceptualisation du processus permettant d'établir 'un objet contenant' dans l'esprit du patient au cours de l'analyse. Les implications techniques présentes dans ce modèle proviennent principalement de concepts et notions avancés par Wilfred Bion dans trois articles et que le présent auteur explique. 'Une théorie de la pensée' (*A theory of thinking*) (1962/1988) où Bion insiste sur ce qu'il appelle 'l'identification projective réaliste' qui fonctionne comme une forme de communication inconsciente et nécessite une compréhension de la part de l'analyste dont le but est le développement des pensées et d'un système avec lequel on peut penser la pensée; 'Notes sur la mémoire et le désir' (1967/1988) dans lequel il lance certaines 'règles' pour le travail analytique qui est centré sur le 'ici et maintenant' de l'interaction thérapeutique évolutive; et dans son article sur 'l'Evidence' (1967/1987) dans lequel il s'attache sur le 'fait' du vécu émotionnel de l'analyste

individuel. L’auteur montre aussi à travers la présentation de quatre vignettes détaillées, certaines des façons par lesquelles le processus analytique échoue ou réussit, mettant en évidence l’importance de la capacité qu’a l’analyste pour la ‘rêverie’, la ‘transformation’, et la ‘publication’—tous étant des aspects de la fonction de contenir. De plus, elle s’étend sur l’oeuvre de Bion et traite de l’importance de ‘prendre le transfert’ (*taking the transference*) et établit une différence entre les deux dimensions principales de l’interprétation, ‘projective’ et ‘introjective’.

In dieser klinischen Arbeit stellt die Autorin ein zusammenhängendes Modell vor, um den Prozess zu konzeptualisieren, ein ‘containing Objekt’ im Analysanden im Verlauf einer Analyse herzustellen. Die technischen Implikationen, die in diesem Modell angeboten werden, stammen hauptsächlich von Konzepten und Begriffen, die in drei Schriften Bions vorgestellt werden, und von der Autorin hier erläutert werden: ‘A theory of thinking’ (1962/1988), wo Bion betont, was er ‘realistische projektive Identifizierung’ nennt, die als eine unbewusste Form der Kommunikation an den Analytiker dient und die ein Verständnis seitens des Analytikers hervorruft, das auf die Entwicklung von Gedanken und eines Apparats, mit dem man Gedanken denkt, zielt; ‘Notes on Memory and Desire’ (1967/1988), in dem er einige ‘Regeln’ für die therapeutische Arbeit vorstellt, die sich auf das ‘Hier und Jetzt’ der sich entwickelnden therapeutischen Interaktion konzentrieren; und seine Arbeit über ‘Evidence’, (1976/1987), wo er sich auf die ‘Wirklichkeit’ des emotionalen Erlebens des individuellen Analytikers konzentriert. Mithilfe der Vorstellung von vier detaillierten Vignetten zeigt die Autorin auch einige der Wege auf, wie der analytische Prozess vorwärtsgen oder scheitern kann, indem sie die Wichtigkeit der Fähigkeit des Analytikers für ‘reverie’, ‘Transforma-

tion’ und ‘Publikation’ hervorhebt—all dies sind Aspekte der Funktion von ‘containing’. Darüberhinaus erweitert sie Bions Werk mit einer Diskussion der wesentlichen Funktionen des ‘Annehmens der Übertragung’ und unterscheidet zwischen zwei Hauptdimensionen der Deutung, ‘projektiv’ und ‘introjektiv’.

En este artículo clínico, la autora presenta un modelo coherente para conceputar el proceso de establecer un ‘objeto contenedor’ en la mente del analizado, en el transcurso del análisis. Las implicaciones prácticas de este modelo se derivan, en lo sustancial, de conceptos y nociones de Wilfred Bion, presentados en tres artículos, y que la presente autora explica: ‘Una teoría del pensamiento’ (1926/1988), en donde Bion enfatiza lo que él llama ‘la identificación proyectiva realista’, que funciona como una forma de comunicación inconsciente con el analista, en que le pide una comprensión dirigida al desarrollo de los pensamientos y un dispositivo que permita pensar el pensamiento; ‘Notas sobre la memoria y el deseo’ (1967/1988), en donde presenta unas ‘reglas’ para el trabajo analítico centrado en el ‘aquí y ahora’ de la interacción terapéutica en evolución, y su artículo sobre la ‘Prueba’ (1976/1987), en donde se concentra en el ‘hecho’ de la experiencia emocional del analista individual. La autora también demuestra, a través de la presentación de cuatro viñetas detalladas, algunas de las maneras en que el proceso analítico puede fracasar o tener éxito, subrayando la importancia de la capacidad del analista para el ‘ensueño’, [*reverie*] la ‘transformación’, y la ‘publicación’—que son todos aspectos de la función de contener. Adicionalmente, lleva más allá el trabajo de Bion, con una discusión de los aspectos esenciales de ‘tomar la transferencia’; y diferencia entre dos dimensiones principales de la interpretación, ‘proyectiva’ e ‘introyectiva’.

REFERENCES

- BICK, E. (1968). The experience of the skin in early object-relations. *Int. J. Psychoanal.*, 49: 484–86.
- BION, W. R. (1962/1988). A theory of thinking. In *Melanie Klein Today, Vol. I*, ed. E. Spillius. London: Routledge, pp. 178–86.
- (1967/1988). Notes on memory and desire. In *Melanie Klein Today, Vol. II*, ed. E. Spillius. London: Routledge, pp. 17–21.
- (1976/1987). Evidence. In *Clinical Seminars and Four Papers*, ed. F. Bion. Abingdon: Fleetwood Press, pp. 239–46.
- FREUD, S. (1901). Fragment of an analysis of a case of hysteria. *S.E.* 7, pp. 7–124.
- KEATS, J. (1817). From a letter to George and Thomas Keats, December 21, 1817. In *The Norton Introduction to Literature: Poetry*, ed. J. Paul Hunter. New York: W. W. Norton & Co. 1973, pp. 477–8.
- KLEIN, M. (1946). Notes on some schizoid mechanisms. In *Envy and Gratitude and Other Works*. New York: Dell Publishing, pp. 1–24.
- MANCIA, M. (1981). On the beginning of mental life in the fetus. *Int. J. Psychoanal.*, 62: 351–7.
- MITRANI, J. L. (1995). Toward an understanding of unmentalized experience. *Psycho-*

- anal. Q.*, 64: 68–112.
- (1999). The case of the ‘flying Dutchman’ and the search for the containing object. *Int. J. Psychoanal.*, 80: 47–69.
- STEINER, J. (1994). Patient-centered and analyst-centered interpretations: some implications of containment and countertransference. *Psychoanal. Inq.*, 14: 406–22.
- TUSTIN F. (1986). *Autistic Barriers in Neurotic Patients*. London: H. Karnac Ltd.
- (1990). *The Protective Shell in Children and Adults*. London: H. Karnac Ltd.
- WINNICOTT, D. W. (1958). Reparation in respect to mother’s organized defense against depression. In *Collected Papers: Through Pediatrics to Psycho-Analysis*. New York: Basic Books, pp. 91–6.
- (1960). The theory of the parent–infant relationship. In *The Maturation Process and the Facilitating Environment*. New York: Int. Univ. Press, 1965, pp. 37–55.

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