

WHAT IS PSYCHOANALYSIS?

At this moment you are a privileged fly on the wall. Alan, a 55-year-old man, is 15 minutes into his session with his analyst and is reporting a dream. In the way that flies do, you've noticed the atmosphere. It is still and calm. They both seem completely engrossed in something, though to you nothing appears to be happening. Alan seems to be talking to himself, yet his analyst is listening intently. He is searching for all the details of last night's dream, pulling them back from beneath the shroud which waking threw over them.

Alan says: 'I was on a landing; there were banisters.' He pauses before describing the exact shape and details of the banisters. 'There was a thin man there. I was toppling him over the banisters. He said to me: "When you have lost the 4 stone and the 14 stone, then you might topple over." That's all I can remember.' Alan is thoughtful a while, then talks about the 'toppling over'. He thinks that the sense was that the man might get unbalanced and topple over. He considers whether he might be pushing him over in the dream. He thought there was a way in which the man was suggesting that when Alan had lost the 4 stone and the 14 stone then he might topple over too, might lose his balance.

As Alan thought about different parts of his dream he let his mind follow the thoughts, images and memories that came to him. He thought about his weight loss programme. He couldn't think why he was dreaming about 4 and 14 stone, but it didn't bother him that he couldn't understand that part, something would probably come up later. Perhaps it's because his next goal is 18 stone, he muses. He remembers being thin as a young man at school. In particular he remembers in athletics, competing against an arch rival in running. He remembers something else which happened at that time too. He smiles with surprise, saying that he hasn't thought of it for 30 years until this moment. But now he notices that thinking about this memory makes him feel anxious.

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Just as he's saying this, his analyst notices that as she begins to think of what she might say about the dream she finds herself feeling she'll have to be very careful not to say it insensitively and provoke a fight. Subtly and imperceptibly the atmosphere has become tense. He remembers fighting this rival; really fighting as if to the death. He thinks that he might have completely lost control and killed him if this strange thing hadn't happened at that point. He'd just gone like jelly; he got up and walked away.

After dwelling a little more on the fears he'd suffered as a young thin man about losing control and being violent, he remembers his father's sudden death from a heart attack when he was a boy. What his analyst knows is that this death, so traumatic for Alan, had precipitated his disturbance as a child. He had developed obsessional routines involving checking and re-checking that he had turned off the taps and secured the locks on the windows at night, as if he believed that in some way he was culpable for the death of his father.

Alan interrupts himself to say: 'I went to the doctor yesterday, by the way, to discuss coming off all the pills.' He reminds his analyst that he is currently taking four different pills. He reminds her what each is for: an anti-psychotic, an antidepressant, a beta blocker and a blood pressure pill. They speak a bit about the visit to the GP and Alan stresses both his desire to give up all his medication now that he is improving with the help of his analysis and his need to do it very carefully. He knows someone who came off anti-depressants suddenly, all at once, and nearly died because the doctors hadn't bothered to warn him that it was dangerous. He checked this out with the GP and is stopping at the rate of half a pill per fortnight. His analyst says: 'Perhaps this helps us understand the 4 and the 14 in the dream. While you very much want to be healthy and be doing well in your analysis, and to manage without taking the 4 pills by giving up more every 14 days, you are also afraid that without the pills and the fat jelly you've covered yourself with, you might get unbalanced and be compelled to fight and be violent. Perhaps you fear your violence towards me, your thin analyst, too. The banisters made me think of those outside the consulting room which you see as you come in.'

Alan says, 'Oh yes; I knew I'd seen them somewhere before! But how do I know I won't go mad and do something to you? I just thought of something, just then.' Alan is now very agitated. 'It makes my blood boil the way analysts never defend themselves when they are attacked in the press. You hear one slander after another about Freud and psychoanalysis, and what do you lot do? Nothing!'

We leave them at this point as they unravel the many layers of meaning held in each image of the dream and each communication of Alan's. Their activity resembles the task of going deeper and deeper into the meaning of a poem. Alan is re-discovering his unconscious wishes and fears, those that made him ill in the first place, and finds himself reliving them in the relationship with the analyst where they come alive again. Here he can be supported by her to know about them, however frightening or unpalatable they are, rather than banish them to his unconscious mind. With his analyst's help he can understand the ways in which he reacted to the traumatic events of his early life, he can come to know and understand the person he became and can begin to feel greater freedom to be himself, less inhibited by his fears of murder and violence towards those he loves.

Who are the patients?

It is not possible to link suitability for psychoanalysis to traditional diagnostic labels. Psychoanalysts do make their own careful **assessments** before offering treatment but they are assessing the motivation and capacity to engage with the taxing psychoanalytic process, and this is not usually directly linked to the severity of someone's 'illness' or predicament. There are however situations where we would be very wary, for example where there is an ongoing severe addiction; drugs or alcohol drown thinking and would continually undo any work achieved in sessions. It would also be irresponsible for a psychoanalyst to take on someone with a severe mental health problem who might need hospitalisation, unless special additional arrangements have been made for supporting the person during treatment, including a collaborative GP or psychiatrist available in the background.

Alan sought help for his agoraphobia, his severe eating problem and his depression. He had suffered for years and had received psychiatric help during crises. If you met him you would no doubt recognise that he was housebound and overweight, yet you would also admire him for his intelligence, his wit and his many accomplishments in the arts. Only he and his close family would know of his private suffering and mental torment.

Frank, a man in his mid twenties, had made it into young adulthood, but emotionally felt completely unable to cope with the world of jobs,

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responsibility and relationships. He had trained as a graphic designer but could not use his talents commercially. When he drew he became obsessively preoccupied with his designs, feeling 'pulled into' them. He functioned below his potential, remaining an office assistant. Often he found his mind taken over by glamorous daydreams or furious, repetitive grievances. At other times he would be flooded by panic or dread, and have to deaden himself with excessive alcohol in order to be able to carry on at all. In relationships he clung desperately and possessively to women who would complain that he did not really seem there for them. Inevitably these relationships foundered once the time came for commitment. He felt his life spiralling downwards, experiencing himself watching as though through a glass screen as his friends established themselves at work and started to settle down into family life.

For someone like Frank, psychoanalysis provides a safe space in which warded-off, nightmarish fears, provoked by becoming a fully active, competitive and sexually alive adult, can be named, faced and understood. Frank was helped to tackle the hard but exciting realities of adult life.

Nasima, a 16 year old girl from a close family became unable to go back to school after a half-term break. She felt too afraid of the other girls. Her parents were concerned and took her to an adolescent centre for help. It emerged that Nasima had become deeply confused in adolescence and feared what was going on in her mind. Her fear of becoming a sexual adult was so great that she felt compelled to remain childlike, frozen in time and stuck to her mother. After initial work at the centre, which gave her hope that she could be helped, she went into analysis.

For Nasima and other young people for whom adolescent development feels like an impossible passage, analysis offers a way of understanding the thoughts and feelings which can make a young person feel completely mad and without hope for their future. In many cases it is a way of preventing suicide or long term mental illness. Without analysis,

someone like Nasima would enter adulthood having dissociated herself from her adult sexuality and be forced to live a restricted and phobic life, with her capacity to love, her many talents and ambitions remaining hidden and wasted.

Mary's adoptive parents sought help for her at the age of seven, because of her frequent and unpredictable violent outbursts, her impulsivity and her general insecurity. Mary hated change of any sort and she tended to rush headlong into things without thinking. Her awareness of her body seemed rather poor. She often bumped into things and fell. When distressed she attacked herself violently, picking at scabs, tearing at her clothes or pulling her own hair. She longed for friends but found sharing difficult. She needed to control other children and to be the centre of attention. When frustrated she could lash out at them. She was friendly to adults, when not in a rage; indeed she could often seem rather inappropriately over friendly to relative strangers. She hated ever being on her own and night time separation was almost impossible, leading to fraught bedtimes and disturbed nights for everyone.

Mary had been adopted when she was four and a half. Her birth mother had herself had a very difficult childhood and was a drug addict. She spent six months in psychiatric hospital shortly before Mary's first birthday. During this time Mary was passed among a number of relatives and friends with no consistent carer. This was the first of Mary's many disruptions. Shortly after her mother's discharge the health visitor referred Mary to social services because of concern about her mother's ability to care for her. There were various reasons for the concern for Mary at that time. One concern was that her mother's partner could be violent. It was thought that he did not actually hit Mary but that he regularly assaulted her mother in front of her. Soon after the initial referral Mary was taken into emergency care and then placed with foster carers just before she was three. Eighteen months later she was moved to her adoptive family. The reliable and patient care of her adoptive parents had helped Mary to settle somewhat, but her distress and worrying behaviour continued and increasingly caused severe strain on her, her parents and all the family relationships.

On first meeting Mary her therapist saw a little girl with big black shadows round her eyes, who talked non stop in rather an empty way and yawned frequently. At the end of their first meeting Mary asked her therapist if she would be wearing the same clothes next time. On their second meeting she described her worry that she had forgotten what the therapist looked like. Mary was offered intensive treatment five times a week.

So in answer to the question ‘Who are the patients?’ we find that they are a wide range of different kinds of people: children, adolescents, young adults and older adults. They are people who come to know that they need help, for whom it matters sufficiently to commit to a fairly lengthy treatment and who have some capacity for thoughtfulness and reflection. In the case of child patients they are children whose carers can commit themselves to supporting the analysis by bringing them to their sessions consistently over a long period of time. They are people whose internal world interferes with their development, inhibits their full enjoyment and involvement in their external world; people whose capacity to be involved in creative work, play and loving relationships is seriously impaired. Some are very ill, others less so.

What is psychoanalysis?

The setting for psychoanalysis is designed to allow both analyst and patient to focus on the patient’s inner world, with minimal interference from outside. The patient comes to the analyst’s consulting room, at pre-arranged regular times, with sessions always the same length (traditionally 50 minutes). There are no phone calls or other interruptions; the setting has to be safe, predictable and consistent. Readers familiar with chemistry will recognise the analogy of a ‘controlled environment’ in which you can examine a reaction between chemicals in a test-tube by making sure temperature, pressure and pH are controlled and that there are no contaminating chemicals around.

The **analytic stance** includes respect and alert attention but overall non-intrusiveness. Although the analyst’s personality is bound to come across in many ways, he or she aims as far as possible to stay in the background and let the patient take the foreground. Thus analysts avoid wearing very loud or provocative clothes, or giving political opinions, or talking about themselves. Ordinary social chat is avoided. This can seem very odd to the patient at first, even rude and bad mannered, since we are so used to being put at our ease by the other person, being reassured that they are benign and friendly. However, when you think about it, we often chat socially to a stranger to fend off their suspicion, and make them like us and trust us. It is comfortable to be liked, but the analyst isn’t there to have a comfortable time but rather to uncover the patient’s deepest feelings and anxieties and to understand and help with these. Chapter 8 compares psychoanalysis in this respect with

other forms of therapy that involve a more ordinarily supportive relationship between therapist and patient.

In adult analysis, the traditional use of the **couch**, with the patient lying down and the analyst behind, is customary. Most of the cartoon portrayals of analysts get it wrong. In reality the analyst is completely out of sight, and rarely if ever has a notebook and pencil; writing would interfere with proper listening and involvement. The rationale of using the couch is to free both patient and analyst from the inhibitions and distractions of sitting and watching another person's reactions and expressions. Lying down helps the patient to relax his or her social guard and be more in touch with the inner world, and with more childlike feelings. The patient is asked simply to say whatever comes into their mind, to report their thoughts, feelings and images, without censoring them or trying to make them logical. This is called **free association**. In practice it is very difficult to do. One quickly comes up against things that feel irrelevant or embarrassing, and finds oneself wanting to disobey the rule by censorship and alteration; sometimes one's mind goes completely blank. These reactions are important in themselves and the patient is encouraged to report them too. **Resistances** to free association are as valuable to the process as the relatively uncensored contents of the mind itself.

In child analysis, play takes the place of free association, and the child plays and interacts with the analyst, occasionally using the couch if he or she chooses. Through the child's play, and sometimes through the lack of it, the unconscious inner world is graphically brought to life in the consulting room.

The intensity of **full analysis**, four or five sessions a week, may seem surprising, until the nature of the enterprise is understood. Psychoanalysis involves emotionally based learning, altering deep structures in the mind that have formed over many years of relating to significant others. A deep trust and familiarity with the setting needs to evolve if the most private passions and worst nightmares are to emerge. Many people can only truly expose their vulnerable side where there is a short wait for the next session; Monday and Friday sessions often tend to be more 'closed up' and hard going for both patient and analyst, but are useful times to explore the disruptive effects of separation. The length of an analysis is not set in advance, unless there are unusual external constraints. If it is allowed to take its natural course, an analysis typically lasts years rather than months. Usually analyst and patient agree on an ending date a year or more in advance, as the ending is an important phase to be worked through.

By convention in the UK we use the term **psychoanalytic psychotherapy** to describe treatment three times a week or less. (The relationship between psychoanalysis and psychoanalytic psychotherapy is discussed further in Chapter 8.) Patients seen only once or twice a week may not necessarily use the couch, although many do. Endless circular and unproductive arguments can ensue about what is and isn't 'real analysis'. A few patients make remarkable use of once a week treatment and seem able to launch themselves into a deep and productive analytic involvement with the therapist; and some four or five times a week patients remain aloof and untouched by their analysis for years. It is vital to assess what a patient can manage and use at the particular point in their lives when they come for help. However the authors would like to stick their necks out and say that in their experience the differences are very noticeable. When it is possible, more intensive work with most patients deepens more quickly and is more efficient and effective.

The value of definitions is also partly to give us a baseline for study and debate. If we are referring to discoveries resulting from psychoanalysis as a method of investigation, it makes most sense if we all know what we mean by psychoanalysis and what the precise parameters are. Full psychoanalysis is often the seedbed for new discoveries, which then inform the work of colleagues doing less intensive work.

The psychoanalytic process

To return to the process itself, an important source of resistances to free association from the beginning are unbidden thoughts about the analyst him or herself. You rather like her dress, and she has an amazingly sexy voice. That picture in her waiting room is a bit lifeless and twee, and you remember now you wondered if she was embarrassed when you first spoke to her on the phone. These are all things you surely can't possibly be expected to say to a relative stranger! It would only be all right if you knew her well, if she had told you quite a bit about herself, and if you were confident that she liked you. You have a feeling that she might feel hurt and offended, and then subtly take it out on you later. Or she might get flattered and seduced and things would get out of control.

Such thoughts and worries are part of the immediate **transference** to the analyst and the whole analytic situation, which give valuable insight into each individual's unique way of seeing and relating. There are always little hooks to hang transference on, real features of the analyst's appearance, tastes and personality, but sometimes it

involves a huge misinterpretation of the other. With adults, use of the couch with the analyst out of sight encourages the development of the transference. The patient's particular expectations in relationships, based on personality and previous life experiences, quickly begin to emerge. With little real information about the analyst, preconceptions crowd in to fill out a picture. Outside the consulting room, our customary transferences to everyone we meet are modified by their responses which show us when we are right and wrong in our expectations. The analytic setting is unique in deliberately existing to concentrate, observe and make sense of transference, rather than modify and dispel it. The analyst's position and function means that he or she quickly tends to become clothed with maternal and paternal transference. Examples of other situations where this can happen vividly are with teachers, seniors at work and doctors.

The psychoanalyst's job is to act as a **participant observer**, listening to the patient, but trying at the same time to listen beyond the words to what is being hinted at or evaded. We find that free association, or in the case of children in the consulting room their play, reveals startling patterns and links in the mind that the patient doesn't know about. It is filled with **unconscious communication**. There are many things about people, too, that can only be seen by other people. An analyst with no axe to grind except a wish to help can enable us to see some of the things our best friend knows but could never tell us.

The analyst does not and cannot remain a neutral observer. He or she has really to take in what the patient is saying, and become affected and involved, all the while trying to keep on observing and thinking. Self-observation is crucial for the analyst: monitoring the real emotional effects of the patient, a willingness to be on the receiving end, the better to understand the patient's ways of relating. This experience of the analyst is referred to as the **countertransference**. Two examples will help to show the subtle interplay of transference and countertransference.

Doug reproaches his analyst angrily when she gives him notice of a week-long break in the analysis. She feels guilty but also defensive, and wants to justify herself. She has to be able to feel the strength and particular quality of his rage directed towards her personally, over something real in the analysis. She has to hold onto the experience without discharging it in action, in order to make proper sense of it.

The analyst in this situation needs neither to take the moral high ground nor to retreat into a quick apology and explanation (which would be the easiest thing), but to think: 'Why this?', 'Why now?' and 'What does this feel like for me, and what does it feel like being Doug at this moment?' The analyst, on the basis of what she knows of Doug, and what the present situation feels like, tries to identify with him in her mind. She might wonder, 'What internal image of me is Doug talking to and reacting to? Is it a parental figure who leaves him unthinkingly, and never takes justified complaints on board? Or am I, at this moment, someone who enrages him by reminding him that he is not the centre of the universe? Or do I feel like one of a couple, off on an exclusive holiday, flaunting my couple-ness and sexuality in front of him?' If she can pinpoint the image and feelings accurately, and make a suggestion to Doug about what is going on and why, she may engage his interest and curiosity about his upset and furious reaction, giving him some relief and new understanding. She takes care not to be defensive or intellectual when she does this, or it might seem to Doug that she is just trying to get out of any real responsibility for his distress and can't acknowledge that her break really does cause him pain.

The analyst thus tries to hold on to the distress, her own and the patient's, and tries to bear it and make sense of it rather than pushing it back defensively, or relieving herself of it quickly by apology and explanation. If she were to do this she would be relaxing the necessary tension of the analytic stance, and reacting more as one might in an ordinary social situation. The sometimes uncomfortable but often productive process of holding on to the tension, bearing the way the patient is feeling and seeing one, while one finds a helpful way of talking to the patient about it, is called **containment**, and the process of making a link in the analysis which invites the patient to think about it, is an example of an **interpretation**. Interpretations made by the analyst aim to bring out the unconscious or latent meaning of the patient's behaviour. They examine the defences in play at the time and often link the past and the present. A **transference interpretation** concerns the live experience in the room between analyst and patient. It has the advantage that it addresses the **here and now**, something that is emotionally 'hot' and immediate in the relationship. A closer look at another session with Doug illustrates all these points.

Doug arrived late for the session following his analyst's announcing her forthcoming break. His explanations for his lateness were all perfectly

plausible. Yet at the same time there was a slightly sulky nonchalance in his manner, suggesting 'So what if I'm late; what's it to you?' She was aware of this but didn't comment.

After a silence in which he sighed and shifted around on the couch, he reported a situation at work in which, yet again, his female boss had let the whole team down by agreeing to two big projects at once. His group had worked flat out on the original project and just as they were likely to get this big order she was effectively withdrawing support and resources, pulling the rug out from under them. His analyst knew that Doug cared deeply about this project. It was a big one for him; a chance to show what he could do. Doug continued, sounding furious and at the same time impotent, almost like a child unable to affect his situation. He spoke about the details of his work situation, the helpless rage of his team, the complaints of his client and the humiliation he felt when telling the client of the delay which was beyond his control. Listening to his distress and complaints his analyst became aware of Doug's fantasy that his boss, a powerful woman, was secretly pursuing her own interests. There was even a suggestion that she had a flirtatious relationship with the other client, which had been at the root of her prioritising that project.

Doug spoke at length and really wasn't interested in his analyst's opinions at the moment. He left no space for her to speak and half an hour passed. His analyst, meanwhile, though silent, was working hard. Recognising his hurt, his rage and his humiliation at work, she felt sure that he also felt those things towards her at the moment. It was unlike him to come late and not be interested in what she had to say. She had to stop herself from defending herself; she wished she could tell him that she didn't want to have to take the week off either. She found herself wondering what it might have been like for Doug as a small boy when his father had left and his mother had protected herself from her grief with a string of brief affairs, often leaving him in the care of her sister.

She found a moment when Doug had paused to think, and said that she thought that he was letting her know how upset and angry he felt with her today, about the unexpected week's break. Doug was in no mood for this and expostulated: 'Huh! You always think it is all about you, don't you!' She suggested that he felt very humiliated by her high-handed decision as if he was unimportant, and as if she didn't recognise how important all that's going on in his analysis at the moment really is. He listened intently. She continued that she had the impression that he was experiencing her like a mother figure who loses interest in him when there is an interesting man on the scene.

Doug was noticeably calmer and in a softer, more reflective voice said, 'It's funny, when I left here yesterday I saw a man in the street

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outside your house. I haven't seen him before and I had the passing thought that he was waiting to see me go before coming in here.' He went on to tell his analyst about a difficulty with his girlfriend. He can get very hurt and humiliated if she talks to other men when they are out. It developed into a big row last weekend, with him accusing her of being self-engrossed and loving all the attention she was getting. He was wondering if it was the same thing, whether in fact he creates these situations. There was a long silence, and right near the end Doug said, quietly, and movingly, I wish my dad had stayed around, then I could have just got on with things without having to keep an eye on my mum, looking out for what she was getting up to all the time.

In the process of arriving at the **insight** that his confusing, hurtful and humiliating experiences in the past are making him behave in destructive ways in the present, the patient has also had a new experience. He has been understood by someone who can really know about and bear his distress, and his anger towards her, someone who goes on trying to understand and help him even in the heat of the moment. In his mind he adds a new figure to his internal figures. Alongside the old expectation of a maternal woman who is preoccupied with her man and doesn't wish to know how that hurts him, there is now an experience of another kind of maternal woman who, while having a life of her own, also has concern for how that affects him.

Here is our second example showing the interplay between transference, countertransference, containment and interpretation.

Katherine had experienced considerable deprivation and abuse, including some sexual abuse, in childhood. As a young adult her problems were compounded by sexual abuse by a therapist who was 'helping' her.

Her analysis was characterised by periods of utter despair in which she lay silently, unable to speak, yet conveying a desperate feeling that something must be done as she could do nothing for herself. Her analyst felt impotent and useless, as without any associations from Katherine she was hampered in being able to make sense of this terrible experience.

In a session well into the analysis Katherine talked graphically about the way in which her mother used to shut her up when she was deeply distressed and complaining by giving her food. In the session Katherine and her analyst were thinking again about why the therapist had abused her. In the past Katherine had felt either unbearably guilty herself or filled with hatred and rage against him. Now her analyst, drawing on her own frequent experience of helplessness in the face of Katherine's despair, speculated that perhaps he had found Katherine's damage, pain and helplessness quite intolerable and had felt that he must at all costs find some magical way of shutting up her distress, perhaps in some ways similar to her mother's feeding. The session had continued with further exploration of this idea.

In a session soon after this, Katherine was again plunged into a deep depression, unable to offer her analyst anything with which the analyst could help her. Her analyst experienced near unbearable feelings of guilt at not helping her patient in her terrible distress, but stayed in role as her analyst, listening, thinking and trying to make sense of things. Near the end of the session, Katherine said scathingly to her analyst: 'So I suppose you haven't got a magic wand to help me then.' The analyst replied that it was terrible for Katherine to feel that her analyst could do nothing to ease her desperation. When she felt this bad she wanted anything, however drastic or destructive, to relieve her misery and felt furious that her analyst would not take action. And yet, in the light of their discussion a few days ago, she thought that there must be a part of Katherine that was relieved that the analyst could bear her painful state without recourse to a magic wand.

Katherine returned the next day, thoughtful and less depressed. She said that she had thought a great deal about what the analyst had said. The thing that stayed with her most of all was the idea that it might be terribly hard for the analyst to be with her when she was like this and that the analyst might be feeling the pain and the helplessness. The analyst remarked that on previous occasions Katherine had imagined that, because the analyst did not *do* anything, she was just sitting there untouched. If her analyst didn't take some kind of action, then maybe she didn't feel Katherine's pain. It had felt to her that there was nothing between jumping into action and complete unconcern. Katherine said with surprise in her voice that that was right.

In this example over the period reported, the analyst talked to her patient in different kinds of ways. When talking about the therapist's abuse they were thinking together about a new way of understanding his actions. This was a helpful part of their discourse; it

was not a transference interpretation but did draw on the analyst's countertransference that she had struggled with and thought about over many sessions. The transference interpretation a few days later, when they were back in the thick of the familiar and impossible experience, drew on the hypothesis that had been made in the earlier session. It is in the transference interpretation that everything came together for Katherine and in which she experienced change. She came back reporting the entirely new experience she had had with the analyst as a new object, an analyst who felt under extraordinary pressure to shut up her pain, but went on thinking and trying to help in a more constructive way.

The psychoanalytic relationship may appear from the outside to be an artificial one. In fact it comes to contain all the complexities and passions of any close human relationship. The unusual feature of it is the analyst's restraint, his or her attempts all the time to think rather than spill out an immediate reaction to the patient. This is only completely possible in theory though, and in practice the analyst will often tend to be pulled a bit without knowing it, into reacting, fitting in with what the patient wants or expects. The patient's customary relationship patterns will thus tend to be **enacted** in small ways. It cannot be stressed too strongly, here, that we are not talking about gross acting out by the analyst including lapses in confidentiality or inappropriate boundary violations, such as those of Katherine's first therapist. But subtle enactments are inevitable as the analyst picks up unconscious cues from the patient as to how to respond.

Mark, who was very stuck and restricted in his life, would come to a session enthusiastic about a possible new job, and his analyst would feel pleased for them both that things were moving. Then over the following days he would lapse into passivity, mentioning vaguely that he had forgotten to phone for the job application, or had lost it. The analyst found herself disappointed and restless, wanting to prod Mark into action, and would notice she was making slightly bossy sounding comments about his inaction. He would become more passive while she would become more active, all the time trying to hide her irritation. At times she would find a sharp edge entered her voice, in spite of her efforts to go on thinking and containing. In response, Mark would sound a mixture of meek and subtly mocking. It would start just a bit to resemble the sado-masochistic way Mark and his authoritarian father related to each other.

The analyst needed to find a way of reflecting to herself about this situation. She had to get outside her own feelings and impulses, and be able to observe this whole situation. Only then could she make an interpretation that engaged Mark's curiosity, showed her understanding of his situation and had a chance of helping him to alter rather than just go on repeating a lifelong pattern.

It is tempting in analysis to make intellectual links without a real connection to powerful wishes and feelings. But intellectual links by themselves are not nearly as effective.

Beth knows intellectually that she always defers to older men and loses her clarity of thinking, because her father liked to prove he was cleverer than women, and she couldn't bear to humiliate him. However, over the course of many occasions on which she has deferred to her analyst, and he has pointed out to her that she is doing just that, Beth has come to recognise the pattern. The fact that he seems interested that she is doing it, that he doesn't just go along with it but questions why, suggests to Beth that he isn't the vulnerable father figure she thought he was at first. She begins to show an argumentative and keen intelligence and finds that her analyst, far from putting her down, or becoming humiliated, engages with her as an equal. Father remains in her mind as vulnerable but he comes to fill less of her horizon. He becomes simply himself rather than a template for maleness.

Soon Beth reports that when she visits home she tends to feel sometimes tender, sometimes irritated with her father about his vulnerabilities, but is no longer inhibited by him. She also finds herself getting to know him in a deeper way and finds that he is not quite as intolerant as she had thought. Her image of him had been limited and caricatured; the development of their relationship had been stifled by their repetitive and stereotyped reactions to each other. Her self-justifying and time consuming internal dialogue with him ceases to intrude on her life. Her world becomes a bit larger and freer.

It should have emerged by now that analysis seems to work in a number of ways. We have spoken of the importance of **containment** and of experiencing and of internalising a new figure. Patients also come to own, sometimes reluctantly at first, previously disowned feelings and thoughts, parts of the personality that don't fit easily with how they would like to see themselves. In order to be rid of

unwanted aspects of oneself, whole areas of the personality may be stunted or rejected. For example, Nasima's terror of her developing sexuality and her fear that as she became a sexual person in adolescence she would become uncontrollably promiscuous meant that she could not develop any adult sexual identity at all. She was inhibited and held back in her whole development. Gradually in analysis she could reclaim her sexual feelings and fantasies, re-experiencing them in relation to her analyst in the transference. Through the work she could be helped to understand her fears and could begin again the developmental process of adolescence, this time with the hope that she wouldn't be overwhelmed by impossible and forbidden sexual wishes.

Psychoanalysis can help to moderate what Freud called **the compulsion to repeat**. This unconscious tendency can lead us to re-enact the same situations that have previously caused distress, despite our conscious wish to do things differently next time. Alan, the patient who was exploring his dream in our first example, restricted his life in response to his unconscious fear of his own murderous violence. Yet he would find himself constantly feeling belittled and driven to a violent response, his worst and most feared situation. Nasima, whose inhibited behaviour served to guard her against sexual promiscuity, tried to move forward and to come to her sessions in a cab rather than requiring her mother to drive her each time. But on her first attempt she found herself accidentally getting into a car that she 'thought' was her cab, with a strange man who was actually waiting for someone else.

Through the experience of analysis Alan and Nasima both came to recognise the ways in which they created an external situation to enact and elaborate their internal view of themselves in relation to others. Once recognised and understood through many enactments in relation to the analyst, it slowly became possible for both of them to see their part in the constant re-creation of distressing life events, and to engage more actively in different, more constructive ways of relating.

Internal relationships re-create and distort the relationships of our daily life. For example, Beth's deep conviction that *all* men were vulnerable and had to be deferred to, showed itself in the way she related to her male analyst. He became the externalisation of her internal picture of the father of her childhood. Through analytic interpretation of the numerous occasions when there was a live expression of this internal picture, change came about. It could be described as reality testing the internal world and modifying it in the light of new information.

Change is also facilitated in a more general way through the provision of a safe and consistent setting for blocked development to unfold. The analytic stance is one of enquiry. It is a non-moralistic, non-judgemental attitude that over time and with interpretation comes to be internalised by the patient. It tends to modify or replace the harshly judgemental, mocking or contemptuous **superego** with which the patient comes to treatment. For example, over time Alan began to understand some of the aggressive and overbearing behaviour which he exhibited towards the analyst and others and which he despised in himself. He could see how he had responded to traumatic losses and separations in his early life with fear and a self-preservative omnipotence and aggression with which he hoped that he would hold on to his loved ones, and force them to stay with him. Recognising this, and experiencing his analyst's understanding of it, despite his attacks on her, meant that he could be more understanding of himself and soften his need to act cruelly. Put another way, he had internalised a more supportive, understanding and encouraging conscience and guide to his behaviour.

It may seem from reading the examples above that, following an insight, the work is done. In fact there is the long process known as **working through** to be achieved. Psychoanalysis takes years rather than months. Following moments of emotional and intellectual understanding, old resistances reappear under the sway of the compulsion to repeat. The same situation, now in a different setting or guise, comes into the analytic encounter as freshly as if it had never been worked on. Working through requires the patient to understand how the meaning in the present situation is another version of one that has already been understood. Gradually the patient begins to spot it for him or herself and starts to feel and experience things differently.

The activity of working through is intimately linked with **mourning**, a central concept in psychoanalysis. Mourning and working through both involve the gradual relinquishment of loved but lost people or ideals. Both involve psychic work and pain and both take time. Analysis involves the giving up of wished-for but unrealistic views of ourselves and patterns of relating. Old positions are mourned so that we become free to gain new ground. We also have to realise that we cannot become different people; through analysis we become more deeply and fully ourselves.

Suffering is part of the human condition; it is as much through losses, conflicts and failures as through success that human beings develop. But for those whose suffering dominates, whose internal conflicts inhibit development and whose failures get repeated,

psychoanalysis can modify destructive patterns and offer the possibility of greater freedom to take control. As Freud himself put it, when asked how psychoanalysis can help if illness is connected to early experience which itself cannot be changed: ‘much will be gained if we succeed in transforming your hysterical misery into common unhappiness. With a mental life that has been restored to health you will be better armed against that unhappiness’ (Breuer and Freud, 1895: 305).

In this chapter we have tried to show something of what psychoanalysis is, how it works and the kind of people it can help. Since our aim was to give a flavour we have not given references for the multiple sources of the theories and ideas. Other useful introductory texts which the reader can consult are Bateman and Holmes (1995), Sandler et al. (1992) and Budd and Rusbridger (2005). In the next chapter we will describe some of the major theoretical linchpins of psychoanalysis, which inform and direct our work.