3

"R"—THE ANALYST'S TOTAL RESPONSE TO HIS PATIENT'S NEEDS

This chapter contains a number of themes each of which requires a paper to itself. In considering them together in their relatedness, I am having to condense, and am risking being misunderstood, owing to the inevitable distortion and loss of clarity. At the same time, I am making the one chapter long and weighty. I hope to do more justice to my themes later when I can develop them further separately.

The ideas that I am putting forward follow on from those expressed in chapter 2. They have come to me both through analyses of my patients and through my own analysis. I will illustrate them with some material from the analysis of one patient in particular.

Most patients I have analyzed come into the category known as "psychopaths" and "character disorders," some of them being quite seriously ill and disturbed people with a great deal of psychotic anxiety. Although much of what I have to say seems to apply mostly to patients of this kind, I do not think it is in any way limited to them, but can also apply to both neurotic and psychotic patients.

THE SYMBOL "R"

In chapter 2 I tried to find an agreed definition of *countertransference,* and found that "the term is used to mean any or all of the following":

a The analyst's unconscious attitude to the patient.
b. Repressed elements, hitherto unanalyzed, in the analyst himself which attach to the patient in the same way as the patient "transfers" to the analyst affects, etc., belonging to his parents or to the objects of his childhood; i.e. the analyst regards the patient (temporarily and varyingly) as he regarded his own parents.
c. Some specific attitude or mechanism with which the analyst meets the patient's transference.
d. The whole of the analyst's attitudes and behavior toward his patient. This includes all the others, and any conscious attitudes as well.

Humpty Dumpty said, "When I use a word it means just what I choose it to mean—neither more nor less," and when Alice questioned whether you *can* make words mean so many different things, he replied: "The question is, which is to be Master—that's all." Our difficulty here is to get one word *not* to mean as many different things as there are people using it.

Besides the confusion between these various meanings the term *countertransference* has also come to be invested with an emotional charge, which makes discussion difficult. It is obviously impossible to avoid either the confusion or the emotional charge altogether, but to reduce both to a minimum, I am introducing a symbol, *R,* to denote what I am talking about, defining it as "the analyst's total response to his patient's needs, whatever the needs, and whatever the response."

DEFINITIONS

Total Response

In using the expression *total response* I have deliberately chosen an omnibus word, and I want to make my position clear about it. I am using it to cover everything that an analyst says, does, thinks,

imagines, dreams, or feels, throughout the analysis, in relation to his patient.

Every patient who comes for analysis has certain needs, and to these his analyst responds in a variety of ways. The response is inevitable, and valuable; it is an indispensable part of the analysis, providing a large share of its driving force. It is the resultant of the balance, interplay, and fusion between the analyst's love for his patient and his hate of him.

What an analyst says and does in the analysis of patients is often separated out into "interpretation" and "behavior," with the belief that only "interpretation" is of any real use to the patient. Such a separation in itself is false, for the giving of an interpretation is in fact a piece of behavior, as are its form, timing, etc. These are no less matters of behavior than are the analyst's shaking hands with the patient, or not shaking hands, the conditions he provides (both for the patient and for himself), his silence, listening, reacting, or not reacting.

All these things are the outcome of his feelings, whether conscious or unconscious. However much he is aware of, there is always far more that is unconscious, which exerts more dynamic pressure than that exerted by what is conscious.

Limitations can be imposed to make the amount of interpretation maximal and of other kinds of behavior minimal, but too great limitation leads to rigidity and stereotypy. Limitations cannot be absolute or standardized. It would not be desirable even if they could, as it would only too soon involve the negation of a basic principle—that of the value of the individual (both to himself and to society) whether that individual be the analyst or the patient.

Needs

Needs in this context is another omnibus word, also deliberately chosen. The ultimate need in every case, of course, is the gaining of insight with growing appreciation and apprehension of reality. But on the way to this many severely ill patients have other needs which have to be met; if they are not met, analysis becomes impossible. The most obvious is hospitalization, but short of this there are many times when an analyst has to intervene. Arrangements for care by the family doctor, control of drugs, contacts with relatives or friends,

control of acting out (often necessary for the patient's safety)—all these may be needed, apart from the ordinary routine fixing of the conditions for the analysis such as money arrangements, times of appointment, and, of course, the initial choice of patient.

Without these things, in many cases no amount of understanding or of careful and accurate interpretation will make it possible for the analysis to be carried through. With them it may be possible, even though they may be felt by both patient and analyst as interfering and delaying; only the outcome of the analysis will show whether they really were so or not.

RESPONSIBILITY

Responsibility in analysis is not a simple thing; the analyst has not only a responsibility to his patient. He has also a responsibility to himself, to psychoanalysis, and to the community. There are many responsibilities which his patient or society would like to put on him, but there are also limits to his responsibility.

For the whole of his response to his patient's needs, the analyst's responsibility is 100 percent. I have considered this statement carefully to see whether it should be qualified or modified in any way and cannot find that it should. The analyst's words, ideas, feelings, actions, reactions, his decisions, his dreams, his associations, are all his own, and he must take responsibility for them even though they arise from unconscious processes. No responsibility for them can be shared with anyone else, nor can they be delegated. This seems to me to be true, unvaryingly, for every analysis.

What does vary comes within that 100 percent responsibility, i.e. the extent to which the responsibility can be delegated or shared, and to or with whom. The decisions when to delegate it, and how, are still the analyst's responsibility.

There are roughly three classes of patient, the outlines of the classes being ill-defined and variable; any one patient at different stages of the analysis may pass from one to another.

1. Frankly psychotic patients, for whom responsibility has to be delegated to other people—doctors, nursing staff, relatives, etc.—for purely practical reasons. Suicide risk, danger to others, general irresponsibility and violent acting out are the commonest reasons. In these cases the strain is largely carried by the patient's environment and so can be lifted temporarily from the analyst.

2. Plainly neurotic patients, where responsibility can be delegated to the patient himself. This depends on the presence of an intact ego and a good reality sense, for the taking of responsibility is one of the highest functions of the ego, and is closely related to stability. These cases are least strain for an analyst, as the patient bears his own strain to a large extent. But it is important that both analyst and patient recognize that there is this sharing or delegation of responsibility, and that the ultimate responsibility throughout the analysis is on the analyst. A time comes in every analysis when the patient needs to bear his own strains, and to take over responsibility for himself, but he needs to understand what is happening and why. In any case, owing to the conditions in which we work, some such sharing or delegation is unavoidable.

3. Between these two groups there lies the large group of "character disorders," "psychopaths," and "borderline psychotics," for all of whom any kind of delegation is extremely difficult and often impossible. It can be done temporarily as in either of the other groups, but usually only to a limited extent.

In this class of patient the therapist's responsibility can be seen most clearly, and the "management" of the case is of great importance. This is the type of case which puts perhaps the greatest and most continuous strain on the analyst himself, for the very reason that delegation is so difficult. Patients in each of the other groups involve it in certain phases of treatment, especially transition phases—e.g. when a psychotic leaves the mental hospital or a neurotic is in a temporary regressed state.

There are limits to the responsibility of the analyst: no human being can carry more than a certain amount of it. It is worthwhile remembering that no one is under obligation to do analytic work unless he chooses, and no analyst is compelled to take on very disturbed patients. He has the right to refuse to undertake an analysis in conditions which he considers unsuitable or unsafe, and to refuse to continue if the conditions are changed for any reason after the analysis has begun.

Two other self-evident things are often forgotten, even by analysts. No analyst has to attempt the impossible, and he does not have to have 100 percent ability to understand or interpret; even in a long analysis there will be many things left at the end, not understood by either patient or analyst.

Every patient needs at some point in the analysis to become aware of the responsibility which the analyst is taking (whether that includes the responsibility for his life, or his acting out, or not). It is surprising how few patients have any idea that the analyst takes any real responsibility whatever in regard to them. Various writers, from Freud and Ferenczi onwards, have described the way in which the patient uses the analyst as an ego; Phyllis Greenacre puts it: "The analyst acts like an extra function, or set of functions which is lent to the analyzand for the latter's temporary use and benefit." I think this is as true of the responsibility function of the analyst as of anything. Stability in the analysis depends upon it, and the patient's ultimate capacity for taking his own responsibilities depends on his having a reliably responsible person with whom to identify.

COMMITMENT

The taking of responsibility involves first of all the making of an accurate assessment of the patient, as regards both superficial levels and deeper ones. This does not, of course, mean immediate recognition of all that the deeper levels contain, but that they are there, and to what extent they are contributing to the success or failure of his life and relationships, i.e. to what extent and in what kind of way he is disturbed. This knowledge has to be gradually increased, widened, and deepened until the patient is as fully known as possible. It means, in effect, recognition of the patient as an individual, a person; the realities of his childhood and his present life need to be understood, as well as his fantasies. The analyst both enters and becomes part of the patient's inner world and remains outside it and separate from it.

To do this involves a willingness to commit oneself—100 percent at times. It is only possible to the extent to which the analyst is able to be a person himself, i.e. to have an outline, or limits, and to be able to bear loss of outline or fusion, that is, his capacity for making identifications and remaining uninvolved.

The analyst's commitment of himself is quite obvious in some respects: he undertakes to give the patient at and over certain agreed times his attention, his interest, his energy; all within the ordinary limits of human capacity. He stands committed to his words and decisions, his mistakes and failures as well as his successes.

There are occasionally other kinds of commitment which are

unavoidable. I have had to give evidence, on oath, in a court of law, in the patient's hearing. This does not happen often, fortunately, but commitment of this kind occurs in cases where acting out brings the patient into conflict with the outer world, which then takes action against him. It serves to demonstrate clearly the 100 percent degree of the commitment.

It is difficult to express what I mean by this 100 percent commitment, beyond these more obvious things, in such a way as to make it understandable. Most analysts feel that these things are not the limits of their commitment, but I have not found a complete definition or description of it.

Freud spoke of "evenly hovering attention," and it may be that I am really only speaking of the kind and degree of attention involved when I say that the analyst puts both what is conscious and what is unconscious in himself at his patient's service.

These have to be made available to the patient in forms that have meaning for him and that he can use. These forms may be verbal or nonverbal. The patient's capacity for symbolization and for deductive thinking largely determine the form, and these depend on what has happened to him in his early development. Different patients may need different forms, and for any one patient a form that is usable and meaningful at one time may be useless at another.

Ultimately, of course, the form has to be verbal and interpretative, but an object (apple, biscuit, blanket, etc.), as Mme. Séchehaye has shown, can have an effect *like* that of an interpretation and can be linked with verbal interpretations later, when the capacity to use symbols has been developed far enough.

The full implication of this is that the analyst goes with the patient as far into the patient's illness as it is possible for him to go. There may have to be times—moments or split seconds even—when, psychically, for the analyst nothing exists but the patient, and nothing exists of himself apart from the patient. He allows the patient to enter his own inner world and become part of it. His whole psyche becomes liable to be subjected to sudden unheralded inroads, often of vast extent and long duration. He is taken possession of, his emotions are exploited. He has to be able to make all kinds of identifications with his patient, accepting a fusion with him which often involves the taking into himself of something really mad; at the same time he has to be able to remain whole and separate.

Unless the analyst is willing to commit himself and makes that commitment clear, it is often quite impossible for a patient to commit himself to his analysis. To commit oneself means to give something and to waive one's rights. Very deprived people cannot give anything until they have first been given something; neither do they believe that they have any rights. It has to be made clear to them that something *is* given, that it is given willingly, and that it is part of the analysis for it to be given, and therefore they have a right to have it.

What is given is not given out of the analyst's need to give, but out of the situation where person-with-something-to-spare meets person-with-need. It is essential that the analyst fully admits that what is "to spare" and is given is limited; it is of the nature of a "token" or a "stand-in" and does not in fact really fit the patient's need (though the more nearly it can fit the better), as the deepest needs cannot really be met except by enlargement of insight and grasp of reality.

FEELING

This commitment, whatever its range, involves feeling. The analyst has to be willing to feel, about his patient, with his patient, and sometimes even for his patient, in the sense of supplying feelings which the patient is unable to find in himself, and in the absence of which no real change can happen. This is so where change is feared and the situation is controlled by the patient keeping his feelings unfelt—i.e. unconscious.

The analyst's real feeling for the patient and his desire to help (there has to be some feeling, whether we call it sympathy, compassion, or interest, to prompt the starting and continuing of the analysis), these need to be expressed clearly and explicitly at times when they are appropriate and are actually felt, and can therefore come spontaneously and sincerely.

Very disturbed patients, and at times even less disturbed ones, cannot make accurate deductions, so leaving these things to be deduced, or even talking about them, is meaningless; there needs to be some actual, direct expression as and when (but not whenever) they occur. In *The House of the Dead* Dostoevsky says, "The impression made by the reality is always stronger than that made by description," and I have found this to be particularly true in this connection. Pretended feeling would be worse than useless, but

absolute restraint of intense feeling is of no real use either—it is inhuman, and it gives a false idea of the aim of analysis to enable the patient to have and express freely his own feelings. It gives the impression that expression of feeling is something allowed only to children or patients but forbidden in a "normal" or grown-up world.

From the point of view of the analyst absolute restraint of feeling is unreal, and it can make too great a demand on him. Self-imposed limitation there must be, but this is not the same thing as absolute restraint; there is no difficulty with less intense feelings which can find their expression comparatively easily in indirect ways.

I have been talking rather of the conscious expression of feeling, whether deliberately predetermined, or on conscious impulse. "Re-acting" is something different. There are times when a reaction of quite a primitive type is not only not bad, but positively helpful. When an angry patient shakes his fist in my face, and I flinch, the reaction is in itself a reminder of reality. It quickly recalls him both to the fact that he could actually damage me and that I am only on one level the person he wants to hurt. Other reactions, not only bodily ones, can on occasion have similar effect and are not altogether to be despised; they can sometimes reach the ego in ways that are closed to interpretation, quite apart from the time factor of their speed.

It has been objected that expression of feelings by the analyst either gives too great gratification or is a burden to the patient. In my experience, neither of these things need be so, though of course they can. Provided the necessary oneness with, and separateness from, the patient are working right, such expressions of feeling tend to happen at the right times. If they are not, then any other way of treating the situation is also liable to make for difficulty.

Reactions, or expressions of the analyst's feelings, however, are not substitutes for interpretations although they may in certain circumstances act like them. They open the way for interpretation by making the patient accessible, i.e. by establishing contact in a fresh area which has hitherto not been reached. Interpretations have to be given as well later when they can be used, otherwise the only change achieved is that of opening the way. If interpretation does not follow, it closes again, and resistance is increased.

Having one's feelings available to this extent is at times a very great strain. To feel real hate of a patient for weeks on end or to be suddenly flooded with rage is extremely painful, as it is accompanied

by guilt. It makes little difference whether the feelings are due to the patient's projections or whether they are objective and called forth by the patient's actual behavior. Real damage can be done if they remain unconscious, but there is little danger if they become conscious. Recognition of them alone brings some relief and the possibility of either direct or indirect expression. Dreams are often helpful in finding the unconscious, disallowed love or hate of one's patient.

Guilt or self-consciousness about these feelings for a patient can lead to both stereotypy and a false separating off of "the analyst" from the rest of the person (splitting, in other words, where it is not appropriate), with results that can be dangerous for very ill patients.

The range of feelings that can be aroused, of course, is enormous. I have spoken of rage and hate, but these follow such things as bewilderment or confusion, incomprehension, fear (of being attacked, that the patient will kill himself, of failure, etc.), guilt. Love, excitement, and pleasure can be as difficult: when a patient at last accepts an interpretation or makes real progress, even when from hating violently his mood and feeling change to something more friendly, a sign of relief may help him to become aware of a change which otherwise he might deny and not recognize. It may also help him to know something of what he is arousing in someone else—again something which he would otherwise be unable to believe.

Like responsibility and commitment, feelings for a patient have their limits. The claims of other patients and of one's own life assert themselves, the material changes, and the feelings change. Unless an analyst is "in love" with his patient, there is no real risk of his feelings getting fixed or of his having to go on and on expressing them, which is what people fear if any feeling is expressed at all.

The benefit to the patient, too, is limited in its extent. Sooner or later he has to realize that no one else can do his loving and hating for him; he has to feel on his own account and to take over the responsibility for it. But meanwhile he has had a feeling person there and the opportunity to identify with him, both by projecting his own unfeelingness and finding the projection, and by introjecting the feeling analyst.

LIMITS; "GOING ALL OUT"

I have shown that responsibility, commitment, and feeling all have

their limits. These will of course vary with the different types of patient treated and the individual analyst. They are of great importance as they provide points of separation.

When a limit is reached and the patient becomes aware of it and aware of the impossibility of going beyond it even though his needs and demands go further, he becomes aware too of his separateness. If his ability to bear separation is very small, then every limit will be reached too soon. The demand on his ego will be too great, and a reaction of some kind (e.g. a piece of violent acting out or the development of a physical illness) may follow unless the situation is very carefully handled. Limits which are within the ego's capacity, whose logic and reality are within his grasp, provide growing points and places where the ego can be strengthened.

In contrast with the limits are the 100 percent of the responsibility, commitment, and acceptance of feeling and reaction. They correspond to the "no limits" of ideas and words allowed to the patient and help to make them a reality.

Some patients are so ill that their treatment cannot succeed without the expenditure of enormous effort, both extensive and intensive. In such cases the difficulty is to get the patient to make his own effort an "all out" one, and it is only if he realizes that his analyst is "going all out" on his behalf that he can find it worthwhile to do so himself.

MANIFESTATION OF THE ANALYST AS A PERSON

Each of these things, responsibility, commitment, feeling, etc., carries with it a manifestation or affirmation of the analyst's self as a person, a living human being with whom it is possible to have contact and relationship.

The idea of the impersonal screen or mirror has served, and still serves, a very valuable purpose in isolating the transference in neurotic patients. But it can be used defensively, even in an almost concrete, nonsymbolic way at times, by either patient or analyst.

For patients dealing with psychotic anxieties, and especially those suffering from actual psychotic illness, some more direct contact with the analyst is necessary. Symbolism and deductive thinking are needed where direct contact is minimized, and both of these are

defective or lacking in such patients. Their development is impaired where the realities of the patient's childhood have coincided with the fantasies which he needed to work through. When this happens, projection becomes not only useless but quite impossible.

Every patient tests his analyst constantly to find out his weak spots and limitations. He has to find out whether the same thing is true of the analyst as of himself—i.e. that the relation of ego strength to instinct-tension is inadequate. If he can prove that his analyst cannot stand anxiety, madness, helplessness either in his patient or himself, then he knows for certain that what he feels must be true—the world will fall to pieces and be shattered by his discharge of tension, whatever the form it takes. Again, since he and his analyst are the same, then they must be one and indivisible.

It is therefore of vital importance to discover that the analyst not only can bear both tension and its discharge, but also can bear the fact that there are some things he cannot stand. The difference between anxiety and panic, and the difference between his own anxiety and fear of his patient's anxiety, can be seen when the analyst can fall, pick himself up, and go on again. This is where recognition of countertransference in the literal sense of the word (second definition) is of greatest importance. It may be necessary for it to be recognized by both patient and analyst, and denial of it by the analyst where it is present and the patient has seen it can have serious results. (Simple admission of it is enough; details are the analyst's own affair, but that there is countertransference affecting the analysis is the patient's affair, and he has the right to the acknowledgment.)

Every analyst, of course, has his own particular areas of difficulty about letting things happen, especially in himself. This relates to the whole problem of control, but it may be essential for some patients to see their analyst react or act on impulse. Remembering the biological origin of both reaction to stimulus and instinctual impulse and that not all ego activity is immediately conscious, I think it is a mistake to regard either as intrinsically undesirable or dangerous even in an analyst's work. In any case, when an analysis is moving swiftly and ideas follow each other in rapid succession, or mechanisms are changing, it is impossible to be always a step ahead of the patient or always to think before speaking or acting. One finds one has said something. If the unconscious contact with the patient is good, what is said in this way usually turns out to have been right. Unconscious

countertransference is the thing that is most likely to prompt a wrong response, and the only safeguard against that is the analyst's continuous self-analysis.

The effect on the ego of conscious recognition of one or other of these things in an actual known person (as distinct from either a machine or a "type") is to make it accessible to transference interpretations and to other recognitions of reality. I have often found such a recognition to be a turning point in an analysis. By means of it a human being is discovered, taken in, imaginatively eaten, digested, and absorbed, and built up into the ego (not magically introjected)—a person who can take responsibility, commit himself, feel and express feeling spontaneously, who can bear tension, limitation, failure, or satisfaction and success.

The patient is enabled to commit himself to his analysis, his paranoid anxiety is relieved in a direct way, and transference interpretations can come to mean something to him. He begins to be able to meet reality and to deal with real people instead of with his phantasms. The development of relationship becomes a possibility, with its need for bearing both fusion and separateness and the risk of feelings being aroused in another person, or by another person.

CLINICAL MATERIAL

The material which I am using to illustrate my points consists of some episodes from an analysis. This involves compressing into the space of ten minutes things which belong to ten years. It can give only a very distorted picture, and I am aware that it is only understandable to a very limited extent.

The condensation of ten years into ten minutes is in fact quite appropriate, for my patient, Frieda, has been disorientated in time throughout the analysis, and she has used time in ways that are personal to her and that cannot be readily understood. This disorientation has been her main regressive feature; she has had no regressive illness and very little obvious regression in the sessions.

She was referred to me for difficulties with her husband and children; she also had a skin rash, affecting chiefly her face, vulva, and the inner surfaces of the thighs.

Frieda's childhood in Germany had been a very traumatic one. Her parents were Jewish. Her father was a very brilliant man, but

vain, selfish, and megalomanic. His magical belief that no ill could befall him led to his remaining behind when all his family emigrated and eventually to his death in a concentration camp. Her mother is still alive—possessive to the last degree, mean, prudish, and insincere. She quarreled with her own relatives for years, and then with her husband, breaking up the marriage. She reviles him to her children, and now speaks of the marriage as always an unhappy one. She enjoys quarreling for the sake of sentimental reconciliations.

Both parents exploited their children. Frieda was made to be responsible for the younger ones. She was expected to wait on her father, forced to do things which she might have done of her own accord, if left alone, for she was very fond of him. In return for the mother's compelling her in this way, her father would punish any revolt or shortcoming by beating her severely, especially when she obstinately refused to say she was "sorry" for disobeying her mother. Her mother punished her by hitting her, dragging her upstairs by her hair, and locking her in a dark cupboard. When she was about four years old she was "cured" of masturbation by being put into a cold bath.

Her mother never forgot her crimes, even when they had been punished, atoned for, and ostensibly forgiven—they are kept in "cold storage" and brought out twenty years later, in all their original intensity. She still tries to exploit Frieda emotionally.

This picture of the parents came out slowly. At first they were described as loving, ordinary people, and it was with great surprise that Frieda found she had this other picture hidden away.

Frieda was the eldest child—she was a disappointment to her parents, who wanted a son. She was breast-fed for a few days only, as the milk "dried up" when her father joked to his wife about the child resembling someone else, not him.

At school she was unhappy, being often withdrawn, confused, and in a dream state. At one school she was made the subject of a lecture from the headmaster to all the staff and pupils for taking sweets and eating them under the desk. After leaving school she had one serious sexual relationship and finally married someone else and came to England.

Her friends found her capable, gifted, cultured, generous, and warm hearted. She is all of these, but behind a facade there was a deeply unhappy, wildly impetuous and impatient child, who could

bear neither tension nor separation. Her children were extensions of her own body, as she had been of her mother's, and were unconsciously exploited as she had been.

After she had been coming to me for a year, she told me that a piece of furniture in my room reminded her of a cupboard in her childhood home. The jam was kept there, and she sometimes stole some. Then she told me that stealing was one of her real difficulties. It gradually appeared as part of a much larger pattern of impulsive behavior which brought her into various kinds of real danger. The impulsive actions happened when there was stress of any kind.

The first seven years of her analysis were characterized by failure on my part to make the transference real to her in any way or to "help her to discover it," as she put it later. The analysis was carried out along ordinary lines, within the limits of accepted analytic technique. Many transference interpretations were given, but they were all entirely meaningless to her. The only thing was that often she would give advice or comment to her friends and acquaintances based on things I had said, and even attributing them to me. But still they had no personal meaning for her, and the changes brought about were very slight. Her condition was certainly improved: there were fewer thefts, and her relationships were in general a lot easier. We were preparing to stop although both of us knew that the main difficulties still remained. I could sometimes get her to see where she was transferring something to her husband or one of the children, but never to me. Her emotional attachment to her mother was unchanged, and her mourning for her father never reached.

She had told me a story of a child who went into a room which was forbidden, and guarded, not by Bluebeard, but by the Virgin Mary. The child's fingers were covered with gold which she found there, and she was punished by being cast out. My interpretations about her curiosity, whether about her own body or about me, telling her of her idea about me as the forbidding, punishing Virgin with the hidden gold, meant nothing to her. It seemed that the key to her own locked door was lost beyond our finding.

Suddenly and dramatically the picture changed. She came one day beside herself with grief, dressed all in black, her face swollen with weeping, in real agony. Ilse had died suddenly in Germany.

I had heard of Ilse, among many other friends; there had been nothing to distinguish her from the others. Now I found that the

main part of the transference had been to her and had been kept secret, apparently because of the guilt about the homosexual feeling toward her. She had been a friend and contemporary of Frieda's parents and had transferred her friendship to Frieda when Frieda was six years old.

For five weeks this state of acute distress continued unchanged. I spoke of her guilt about Ilse's death, her anger with her, and fear of her. I said that she felt that Ilse had been stolen from her by me, that she was reproaching the world, her family, and me, that she wanted me to understand her grief as Ilse had understood her childhood unhappiness, and to sympathize with her.

None of this reached her—she was completely out of contact. Her family bore the brunt of it: she neither ate nor slept, and she talked only of Ilse, who was idealized and whose photos were everywhere in the home. She saw Ilse in buses, in the street, in shops, ran after her, only to find that it was someone else. My interpretations that she wanted me magically to bring Ilse to life again and that she wanted to punish herself and her environment for her unhappiness fell on deaf ears—nothing reached her. She could not lie down: she sat for a few minutes at a time and ranged round the room, weeping and wringing her hands.

After five weeks her life was in evident danger, either from the risk of suicide or from exhaustion—somehow I had to break through. At last I told her how painful her distress was, not only to herself and to her family, but to me. I said that no one could be near her in that state without being deeply affected. I felt sorrow with her, and for her, in her loss.

The effect was instantaneous and very great. Within the hour she became calmer, lay down on the couch, and cried ordinarily sadly. She began to look after her family again and a few months later had found the larger flat they had been needing for years, which up till then she had declared was impossible. In fitting it up and moving into it she found a happiness that she had never experienced before, and that has lasted and grown. Her reparative impulses came into action in a wholly new way.

I had often spoken about feelings in connection with myself, but this had absolutely no meaning for her—only those feelings that were actually shown and expressed meant anything at all. She remembered only too clearly having told her mother that she loved her, that

she was sorry for things she had done, etc., with her tongue in her cheek, to say nothing of her mother's exaggerated expressions of a love for her father, which was subsequently denied.

But I had also on two earlier occasions expressed my own feelings. The first was when I had sat listening for the hundredth time to an unending account of a quarrel with her mother about money and also for the hundredth time had struggled to keep awake. It was boring, and as usual no interpretation would reach her, whether it was concerned with the content of her talk, the mechanisms, transference, her unconscious wishes, etc. This time I told her that I was sure that the content of her talk was not the important thing, that it was defensive, and added that I was having difficulty in staying awake as these repetitions were boring. There was a shocked and horrified silence, an outburst of aggrieved anger, and then she said she was glad I had told her. Her accounts of the quarrels were shorter, and she apologized for them after that, but their meaning remained obscure. I now know that I was being to her the (dead) father whom she should have been able to tell how "awful" her mother was, and who should have helped her to deal in childhood with her mother's mental illness. I was also Ilse who should have been with her in all her difficulties. But if I had given this interpretation, I am sure that it would only have met with the same response as all the other transference interpretations.

The second time I had been having some redecorating done. She prided herself on knowing just how this should have been done and had often given me advice in a very patronizing way, which I had interpreted as her wanting to control me and own my house, to tell me things instead of having me tell her. This time I had had advice all day long from one patient after another, it was the end of the day and I was tired and, instead of giving an interpretation, without thinking I said crossly "I really don't care what you think about it." Once again the shocked silence was followed first by fury, and then a really sincere apology. Soon after this came the recognition that most of the good advice she gave to friends and people she met casually in the street or in shops might quite well have been resented and that in her anxiety to control the world she was, in fact, overbearing and a busybody.

After my telling her of my feelings at the time of Ilse's death, and linking it up with those earlier times, she told me that for the first

time since starting her analysis I had become a real person and that I was quite different from her mother. She had felt whenever I commented on anything she did that I was her mother and was saying, as she had always done, "and you are an awful person." This I had known and had told her was a transference manifestation, but all meaning of this interpretation was denied—it, too, only meant "and you are awful." She called me "Lesson 56" in the textbook. Now she could link the textbook with the women's magazines which her mother had read and in which she found many of her fads and fancies. My feelings, being unmistakably real, were different from the counterfeit ones of her parents. They allowed her and her concerns a value which she had never had, except with Ilse. In other words, for her I had become Ilse in the moment of expressing my feelings.

From this time transference interpretations began to have meaning for her. Not only did she now often accept them when I gave them, but she frequently said "You've told me that before, but I didn't know what it meant," and even "I remember you saying many times . . . *now* I understand it," making the application herself of something which she had previously rejected.

Soon after this, for the first time, a pattern began to show in relation to the stealing and other impulsive actions. I was now able to see that they happened only when her mother was visiting her. But they were also increasingly dangerous. One day on her way home from analysis she was run over by a car and badly hurt. I don't know how she was not killed outright. Another time a neighbor of mine asked me, "Is that woman who runs out your gate across the road without looking one of your patients? She's very dangerous." Again, another day when she was expecting a visit from her mother, I went into a main road near my home, at a busy spot, and there was Frieda, twenty yards from a pedestrian crossing, leaping about among the cars, putting everyone in danger, including herself. I showed her the relation of these happenings to her mother's visits, and their suicidal and murderous character. She rejected this idea, as she rejected any idea of herself as ill, and as she had previously rejected all transference interpretations.

A few weeks later, while her mother was staying with her, she was caught traveling without paying her fare, being in a hurry and having no change. The consequence was being charged in the magistrate's

court. I gave her a certificate stating that she was in treatment for her impulsive behavior and that essentially she was an honest and reliable person (which was completely true). This, like my expressions of feeling, made a deep impression, for I had said *openly* the very opposite of what her parents had said when they labeled her "liar" and "thief," and an "awful person." She began to recognize her dangerous acting out, and to be afraid of it, but it still continued.

The next time her mother came she stole again, and now I said I wondered if I should not refuse to go on taking responsibility for her analysis if she had her mother there again. I had already told her several times that I considered that she was taking risks in doing so. At her mother's next visit she stole once more, and I repeated what I had said.

I showed her that she had neither believed in the danger, in the reality of her illness, nor that I could have meant what I said. I assured her that I did, and that if she had her mother there again I could not take the responsibility for her—I would interrupt her analysis.

About this time she spent several sessions telling me of the bad behavior of a child who was visiting her. She had also told me of her little girl's' disobedience, and I had asked why she could not be firm and not allow them to go on doing the same things over and over again. This was an old story; she was never able to get obedience from her children without flying into a violent rage and frightening them into it. She let them do just what they chose, rationalizing it as being "modern," or "advanced," and they would stay up late at night, miss school, etc., and neither she nor her husband could do anything about it—in fact, unconsciously they encouraged it.

I asked her what would happen if I refused to let her go on telling me these stories. I was as tired of them as she was of the children's behavior. She "didn't know," and went on into another story. I said, "I meant that. I'm not listening to any more of them." She was silent, then giggled and said, "It's *awful.* And it's *glorious,* to have you say something like that. Nobody has ever spoken to me like that before. I didn't know it could be like that. You've often told me about telling the children that I won't have them do things, but I simply didn't know how to do it." And from then she began to be able both to accept "no" for herself and to say it.

Now I reminded her that I told her that I would stop her analysis if

she allowed her mother to come again, and of her finding it "glorious." For the next three days she was in a panic and confusion. When it subsided she spent some time planning how to refuse to have her mother to stay. She put her off for some weeks and then the question came up again. Would I tell her what to say? Could she let her mother come, and she would go out and sleep at a friend's house? I showed her that this was no solution and that she had to find her own way of dealing with the situation. After more panic and fury she told her mother for the first time about her analysis and that I had forbidden the visit. This was tantamount to saying "You are an awful person" to her mother.

Next day she had an impulse to steal apples from a neighbor's garden. Just as she went to slip through the fence with her basket she stopped herself. She later sent one of the children to ask for some and was delighted and surprised to be given them.

I showed her that in seeing her mother at all she had in fact defied me, in a token way, as well as obeying me, and that her altered behavior over the apples depended on her having been able to accept "no" from me and to say "no" to her mother. She had found me reliable in that I meant what I said about this and that even if I did stop the analysis I would not be angry. She had begun to believe in the realities she had been denying. From here her feelings about her analysis changed a lot—she began really to suffer, as she never had before, especially at the weekends. One hour was not long enough—she was wanting me all the time and was living in her analysis all day long, even though she was doing her work more effectively and living her life differently. The transference became a reality for her at last.

She had difficulty in folding up the blanket, in deciding whether to bring up my milk when she found the bottles on the step. These were old difficulties, and she found she wanted to do quite the opposite things about them. Here I could show her how much of her feelings toward me had been put on to these things. She described herself as split (it was her own expression, I had not used it) and she showed me how far apart the pieces were, holding her hands about a foot apart. I reminded her that at one time part of her had been here and the other in Germany, in Ilse. She found that she wanted to look at me with "stolen glances," and discovered that she had had two beliefs, one that I was her mother, the other that I was Ilse—both had been held with delusional strength and with an hallucinatory quality which she

could now begin to disperse by consciously checking up with the reality. The stealing came directly into the transference, and she found herself traveling without paying her fare on her journeys to me.

About this time she came into closer contact with my hate of her than she had been before, in a way that meant something real to her. One day we had met by chance at a concert, and she found me afterwards in the musicians' room, to her great surprise. "I didn't know *you* knew X," she said, angrily, and next day discovered that she had meant "What right have *you* to be here?" From there it became possible to show her (as I had often tried to do) how she had been trying magically to control me and to have me with her everywhere. Much of her concert going had been to go with me, and finding me there in reality had disturbed her fantasy. I showed her, too, what it would have meant *for me* to have met her often, to have come up against her possessiveness in that setting. For in her idea of herself, expressed in her behavior and previous talk, she owned not only me but all the concert halls—artists and composers as well.

Recognition of her omnipotent fantasy led to the realization that she had been expecting something unattainable and magical from her analysis. She had believed that it would make her husband, children, mother, brothers, and sister well, back in her childhood, and bring both her father and Ilse to life again. Her "stolen glances" enabled her really to see me as a person for the first time. "I've discovered something. It's very painful, and yet I'm so glad. I found that I know nothing about you, nothing at all. What a fool I've been. I've put all that tremendous effort into trying to make you be something you aren't. Whatever I thought I knew, however I struggled to make myself understand, reading Freud and Melanie Klein, all that effort was so futile. I feel so stupid. I was trying to force you. I'm so sorry." I said she need not be sorry. She glared at me and burst out furiously, "I *will* be sorry if I want to," and then she told me of her secret game of "associations" in which she thought of a scent, a building, a book, etc., to "associate" with me. Now her "secret glances" showed her how unreal it had all been.

Next day I had a cold, and she felt it impossible to talk as anything she said would be attacking me. She recognized that she was wanting something magical, two opposite things at once, to be there and to go away, to protect me and to destroy me. Now she had seen that no

amount of analysis could make it possible. I spoke of the inner world of her imagining and the world of outer reality—only in an inner one could it be like that, and while her inner world and mine might meet in places, they could never be the same. She was silent and, I thought, nearly asleep. She hid under the blanket. When she came out she said she had been trying it out. She had thought, "If I keep quiet I can be here and not be here, and you go to sleep, dear, if you want to." She felt relieved and whole, for it had worked. I told her that she had brought together the inner and outer worlds, allowing herself to have her own and me to have mine. She had been a whole person, separate from me.

The following day she found that she had been able to do something in an unplanned and unarranged way, and it had been good. This had never before seemed possible. And she had discovered a new sort of feeling that she did not understand—she felt gratitude toward someone she did not love and had been able to help someone in a new way. It made her feel different, both toward other people and toward herself. She had been "arrogant" before, now she could be friendly and could like herself. I said she had found that she could like and dislike the same person and so need no longer split me into two and put part of me elsewhere, magically.

Then she recalled an incident when she was four years old. She was out with her father, and she was holding a little stick in her hand, about the size of his penis. He took it and threw it into a stream, and showed her it floating away under the bridge. He said it was her "naughty temper." She could not feel that it had anything to do with her, as she had not been in a temper at the time. She now saw that she had really believed it to be his penis. She had seen it as that and had been disapponted and angry at his taking it from her. She knew now that it was true, as I had said, that she had never been able to mourn for him, as his death "had nothing to do with her." She had "not caused it by being angry" and yet believed that she had.

Here we could see more clearly than before how many things in the earlier part of her analysis had been difficult because of her failure to symbolize. For example, she had often fought with herself as to whether she should bring up the milk bottles she had found on my doorstep or not. It had been utterly impossible for her to decide and useless for me to interpret anything about it or to tell her that it didn't matter which she did. Only now could she see that to her the milk

bottles not only represented me (as I had said) but *were* me, and that she had wanted to kick them off the step, as she had been kicked by her parents and by the car that had knocked her down. But in her delusion it meant actually kicking me. The blanket too, had had the same significance. At last she was free of them, someone else could fold the blanket and bring up my milk. It was no longer her responsibility.

Her ambivalence became clearer. "I hate you because I love you so much," she said; and again, "Damn you and blast you, and bless you, for loving you so much."

Separateness was so far accepted; fusion, or merging, loss of identity has been more difficult. Along with the difficulty in accepting it goes the difficulty of allowing herself only to hate or only to love me, wholeheartedly, now that I am the person toward whom both are felt instead of being the loved person while her mother is hated, or the hated one while Ilse is loved.

She described how she felt she was "inside a capsule and trying to get out, but altogether lost outside it." The capsule is transparent, even invisible. She recalled, as a child of six, having drawn a circle in the sand and sat inside it, believing herself to be invisible and feeling utterly bewildered when someone spoke of how she looked sitting there. A similar thing happened years later when she ate sweets in school not knowing that she could be seen.

Here at last, in her own description, is the basic delusion by which she has lived and which has been her main defense throughout the analysis.

I linked it with an observation which I had made several times before, that I thought she had at some time witnessed the primal scene in a mirror, being screened from seeing directly. I spoke of the difficulty in understanding about a mirror unless someone is there to show the child her reflection or unless there is some familiar and identifiable object that she can see both in the mirror and without it. She said "You've told me before about seeing my parents in the mirror, and I've never believed it. I don't remember it—but I know which side my cot is on—it's on the right side, and I *know* it. I can see a room, but all the furniture's strange—I don't know any of it." Then she recalled hearing that in the second year of her life for a short time the family stayed in an hotel. That was the only time she had slept in the parents' room as far as she knew, and the memory of it had been denied.

The "capsule" represents among other things her identification with her father, the magical father whom nothing could touch. It also represents the magical, invisible penis by means of which she could remain one with her mother and with Ilse. Ilse she kept invisible—until her death shattered the "capsule" and revealed her. My identification with Frieda in her loss and grief restored it, but with me inside it in Ilse's place.

It was this that made both mourning for her father and for Ilse possible, through the analysis of the transference which until then had been inaccessible.

For her to break the "capsule"—to discard her delusions—has meant annihilation, both by separateness and by fusion. Only if someone from outside could break through it forcibly and safely could she emerge as a living, feeling person and only a person with real feelings could do it by making her feelings available. Everything had to be held fixed, magically and invisibly, out of reach of the primitive, destructive love-hate impulses. Now she is sitting among the ruins of a world that she has shattered and is looking for ways of restoring it—not restoring it by trying to bring her father and Ilse back to life, or by trying to make her parents well and happy forty years ago and more, but doing so imaginatively by means of the new creative activities that are already at work in her, activities that we call sublimations.

She is happier now than she has ever been, but also unhappier. Her mourning is not yet accomplished, but she is well on the way to it. Her home is a more reliable place for her husband and children, for she can say a thing and keep to it, she can differ from her husband without having a furious row in front of the children as she used to do, and she can allow them to be individuals. The stealing has stopped altogether, even when her mother visits her. Other impulsive behavior is greatly modified. Her sex life has altered—she can now enjoy it and have genital and psychic orgasm. The skin rash rarely troubles her, and the world she lives in is becoming sane and ordinary (though there may be mad things in it), instead of it being hostile, anti-Semitic, and mad. She knows that it is through Ilse's death that she is getting well, she has accepted her pleasure in Ilse's death, and her hate, her destructive love, and her sadness. The analysis still goes on.

I have not gone into the very complicated psychopathology of this

woman. For my present purpose it is enough to say that her capacity to develop a reality sense had been seriously impaired; symbolization and deductive thinking were largely replaced by concrete thinking. She was unable to distinguish between real visual and auditory impressions and hallucinations, or between reality and delusion. Splitting of the ego while it was still a body ego had resulted in persistent failure to make accurate perceptions, or accurate deductions from such perceptions as she made. The consequence of this was that all her transferences were delusional, and on them were based all her relationships.

She had to be reached, through layer on layer of splitting and denial, on the level of helpless dependence and no-separateness—the level of her paranoid delusion. This, like all other delusions, was not susceptible to transference interpretation: it had to be broken down in the most direct way possible, i.e. through the analyst as an actual person.

IMPLICATIONS FOR TECHNIQUE

The growing realization that there are many patients who cannot make use of transference interpretations until some change has taken place that makes the ego accessible leads to the question of what alterations in technique and in the theory of technique are necessary.

Difficulties in getting transference interpretations accepted, the arising of sudden, unpredictable tensions which often result in violent acting out have been regarded as due to some insufficiency in the analyst—insufficient analysis, failure to deal with his own anxieties, acting out on his part.

Verbalization, understanding, and interpretation have been regarded as all-important. But the need for "working through" has long been recognized as a necessary process in analysis. It is important to understand what is going on during that process and whether there is anything that can be done to help it on.

Looking at patients such as the one I have cited, we find that patients whose reality sense is seriously impaired, who cannot distinguish delusion or hallucination from reality, cannot use transference interpretations because the transference itself is of a delusional nature. Transference interpretation calls for the use of deductive thinking, symbolization, and the acceptance of sub-

stitutes. It is not possible to transfer something that is not there to be transferred, and in these patients their early experiences have not enabled them to build up either what needs to be transferred or a picture of a person on to whom transference is possible. They are still living in the primitive world of early infancy, and their needs have to be met on that level, the level of autoerotism and delusion.

Ways have to be found of presenting reality to these patients, many of whom cannot use it as it presents itself in their daily life.

The reality that is present, available, in every analysis is the analyst himself, his functions, his person, and his personality. It is up to him to find his own token ways of using these to meet the individual needs of his patients, to find out what is practicable, and to set his own limits in the handling of his patient's anxieties, as far as possible determining consciously what he will or will not do, but being willing to act on impulse, and on occasion to react. This is part of his acceptance of himself as he is.

In the early days of analysis no analyst had much personal analysis or much experience (either his own or other people's) to draw on, and in those days, "wild analysis" did in fact lead to danger situations which could not be dealt with. But conditions are different today, and the assertions that certain things are dangerous, or impede the analysis, can be tested out. Many such assertions seem to me to have the mythical or superstitious quality of superego judgments.

We have to recognize that the same paradox that we find in other areas of life is there too in analysis—that the same thing can be both bad and good, that what is most valuable can also be dangerous and useless. This is as true of transference interpretation as it is of answering questions, expression of feeling, acting on impulse, etc., by the analyst. The great need is for flexibility (which is not weakness), reliability, and strength (which is not rigidity), and a willingness to use whatever resources are available.

What I have tried to show is that the results that we all hope for and expect to get can be obtained if we are willing to approach the analyst's attitude to his patient from a new angle and to recognize some of the things that are in fact done in analysis, but often disregarded or not admitted.

My own awareness of them has been increasing. I have been evolving my way of working since 1937, before I began training as an analyst. Later, I tried to discard what I already had in favor of a more

classical or less "unorthodox" technique and failed with a number of patients whom I still feel I would and should have been able to treat. In practice what I do varies widely from one patient to another. It is in itself an expression of the patients' individuality and a confirmation that I am not impressing something on them that belongs not to them but to me. This approach has both advantages and disadvantages. Quantitative measurement is never possible in analysis, but the usual tests and checks can be applied, as in all our work.

The original assessment of the patient's illness can be reevaluated, especially in the light of his response to transference interpretations. If such interpretations are consistently felt by him to be meaningless, even if in fact he shows that they do mean something somewhere, or if on the contrary they are accepted but no changes in behavior or ways of thinking follow, either of these I would regard as pathognomic of the presence of a deep split and a great deal of paranoid anxiety, the defenses against it being stronger in the second case than in the first.

This means that ways of making the ego accessible to transference interpretations have to be found. Whatever is found will have to be subjected to the usual scrutiny. My own questions run something like this:

Why do I do or say this?

How does it relate to things in myself—conscious or unconscious?

Why to X and not to Y?

Would I do or say it to this patient in other circumstances, another day, another time?

What effect does it have, and why?

Does the bringing of new material follow?

Is there any real ego development?

Could the same results be got otherwise? Quicker? Better?

If so, how, and why? and why have I not done something different?

One cannot always answer one's own questions right away. Sometimes the answers turn out to have been wrong; sometimes there is no answer to be found except that it felt right at the time or was the only thing one could find to say at a time when something had to be said. Subsequent events usually show whether it was right or not, and when one finds an analysis going on well where one has done something out of the ordinary, one's confidence in one's own unconscious processes increases. One's counter-resistances seem to break

down more quickly, the work goes on often at a higher tension, and the analyst's greater spontaneity helps the patient to break down his own rigidity and stereotypy.

The main difficulty lies in a general state of unexpectedness. This does not mean everything being out of control, though it often feels like it to the patient. It is rather a state in which things can happen. The risk, of course, is that there may be a sudden "triggering off" in the patient or in the analyst when an unknown factor turns up. This again is something which can happen in any analysis and has to be dealt with when it does.

The account which I have given of one patient's analysis, condensed as it has had to be, could be a very misleading one. The variations in technique which I have shown do not always come off. When they do, the effect is very like that of any right interpretation: there may be rejection first and acceptance later or acceptance straight away. There may be no effect immediately to be seen, and it may appear later that there had been some. When they do not come off, again, as with ordinary interpretations, something may happen or not. And like ordinary interpretations, if the time is right and they are appropriate, their effect is good. If not, the effect is bad, and they are mistakes like any other mistakes. In Frieda's analysis the things I have quoted did succeed and were not mistakes. I think they were not just lucky flukes either, for I have experienced similar things in a number of other analyses with similar results.

The purpose of these things is quite clear, and limited. It is to make the patient's ego accessible to transference interpretation by breaking up a delusional transference.

Interpretation does not make any impression on delusion. The only thing that does so is the presentation of reality in a way that is comparable to waking up out of a dream—that is, finding that something that has been believed to be literally true is untrue, by confrontation with what is true. This does not make ordinary interpretation redundant, nor is it a substitute for it. It does not do away with all resistance. Ordinary interpretative work has to go on before such episodes as I have described, through them, and after them, and it still remains the main part of the analysis. Without it these other things would be useless but, in cases where the transference itself is of a delusional nature, they are the only kind of thing that makes transference interpretation meaningful and usable, for it

is through them that a human being can be discovered behind the interpretations.

SUMMING UP

I have tried to show certain elements, some of which I consider essential, in the analyst's total response to his patient's needs, some ways in which they can be used directly, and the kind of effects that I have found from such direct use of them. They are things that in my opinion need to be made clear at some point in every analysis. They appear more obviously in the analysis of very disturbed patients and less so in that of neurotics. They are there, implicit or explicit, in every good and successful analysis that is carried out, and something of them is there in every analysis that is even partly successful.

The analyst's total love and hate of his patient, which provide the motive force of his total response, contain both some things that are basic and nonvariable and some that are variable. The analysis, as far as the analyst's share in it is concerned, depends mainly upon the quality of the basic, nonvariable part. This, in its turn, depends on the extent to which the analyst's world in which he lives is a sane and friendly one—i.e. on how far he has been able to deal with his own paranoid anxieties and his depression, anxieties that are inseparable from the work that he is doing. If he can rely on it, and consequently on himself, it will probably be safe for his patients to do so, and they will come to do so increasingly. If not, it will probably not only be unsafe but also impossible for them. Then there will be failure and perhaps tragedy.

It is this basic, nonvariable factor that provides the stability of the analysis (again, as far as the analyst is concerned). The variable things, the unconscious countertransferences, the day-to-day or hour-to-hour variations in the amount of strain he is bearing, his health, his outside concerns, all these tend to make for difficulty, especially if they have too wide a range of variation. These are also part of the analyst's responsibility—he has to see to it that the range of variation is not too great and that the variations do not get fixed or unfixed again too easily. But these things, like all the others that I have referred to, can be valuable as well as harmful. They are part of the analyst's life, and they make for life and movement in analytic work.

Analysis is a living thing, and like all living things it is changing all the while. Even in the few years that it has existed we can see many changes, especially in the field of technique. Patients are treated today who would have been thought unsuitable even a few years ago. Mrs. Klein reminded us that such things as analysis of children and interpretation of transference were once looked at askance. We cannot know what analysis will become in the future; we can know only that it will change, that we are contributing to its future, and that today's changes will look different to those who come after us.

"Countertransference," in the various meanings of the word, is a familiar phenomenon. At first, like transference, it was regarded as something dangerous and undesirable, but nevertheless unavoidable. Nowadays it is even respectable!

But I feel that it should be a great deal more than this. We do not know enough about our responses to our patients and have been (on the whole wisely) cautious in using them. But a very great deal of psychic energy goes into them, whether we wish it to be so or not, and if we are to get anything like the full benefit of this energy, either for our patients or for ourselves, we have got to be willing to experiment and even to take some risks. I am sure that experimenting by trained and experienced analysts is essential for the further growth and development of psychoanalysis, but it needs to be done against a background of responsibility, known and willingly taken.