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PSYCHOANALYSIS AND MATERNAL WORK—SOME PARALLELS

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This paper deals with certain dilemmas that are familiar to all practising analysts—in which the analyst asks himself questions about where his patient *is* developmentally. He asks himself these questions in order to decide how to intervene at a particular moment to help the patient get on with the analysis. He asks what kind of attitude and verbal intervention would be most conducive to growth. What I will try to suggest in this paper is:

1) that such dilemmas are similar to the dilemmas *parents* have as they try, from day to day and minute to minute, to decide what would be most useful in facilitating the development of their children;

2) that both analytic strategies and parental strategies swing back and forth between, on the one hand, empathic closeness and support, and, on the other, more objective understanding facilitating individuation, in a manner which is *inherently dialectic*;

3) that this basic similarity between the work of analysts and that of parents is congruent with the growing prevalence in almost all contemporary psychoanalytic thought of object-relations theory, in one form or another.

CLINICAL MATERIAL

I shall begin with two short clinical vignettes which describe very different patients with different pathologies. What I find common to them both is a recurring dilemma of the analyst rather than a specific clinical problem. In both cases, I asked myself the question: what kind of analytic help does the patient need at this moment in order to get on with the analytic work? In both cases I found that the dilemma of the moment had a parallel in a parent–child scenario. Both of these clinical vignettes are concerned with the assessment of what the patient is able to do—psychically, at a particular moment—and what kind of help he needs.

The first example revolves around the question of the kind of assistance that could be provided without breaking the analytic framework. I am referring to doing the kind of things that one would like one's patient to do for himself; such as trying to remember something, assuming that there might be some connection between things that come up in the course of a week; questioning his motivations. Doing these things for the patient, instead of the patient doing them himself, is always a problem. One feels oneself to be 'seeping out of', if not actually 'breaking', the analytic framework.

The patient is a young woman who does not remember from hour to hour what has happened in the analysis. She has a very flat and constricted emotional life and takes very little interest in the movement of the analysis. When the question of her forgetting comes up, she feels guilty, and then the question of the guilt is discussed, but it is very difficult to get her to address herself to this question of 'breaking links', except in the context of guilt—the feeling that she is not doing what she is 'supposed to' in the analysis. She comes to analysis four times a week; on Sunday, Monday, Wednesday and Thursday. (Sunday being the first day of the working week in Israel.) The

analytic week very often takes on a typical 'shape'. After the weekend, she is very remote, silent, empty of thought and emotion; something about the break has caused her to 'turn off the switches'. During the course of the week she becomes more involved, speaks with more liveliness, and sometimes even has things she wants to tell me. This relative forthrightness is again interrupted by the break at the weekend.

In the beginning of this phase—which followed a phase of almost total detachment, with a negativist flavour—I waited to see whether she would observe this 'shape' of the week and elaborate upon it. When she did not, I took this role upon myself. Often, on Sunday, towards the end of the hour, I would give a rather long interpretation, reviewing what had happened during the previous week: her lifelessness and emptiness at the beginning of the week, after the weekend, which then gave way to a greater readiness to relate to me, and was then cut off again by the following weekend. Her reaction to this kind of interpretation was wary, but thoughtful. She often made remarks to the effect that 'it sounded right', but whereas in the first, more detached stage of the analysis this sort of response meant 'maybe it's logical to your theory, but it isn't relevant to me', at this point, it seemed to have more of the flavour of 'it feels right, but I can't go very much further with it'. However, it did have a 'softening' effect, in that it made it possible for her to become more involved and forthcoming in the analytic hours during the week.

As this weekly procedure repeated itself many times in the course of many weeks, I became more and more concerned with the fact that although my interpretation seemed to help her to continue with the analysis, she was unable, or unwilling, to take upon herself this function of reflecting about what was happening and using our shared experience to become more autonomous. I was remaining the caretaker of her emotional life, the container of her memories and self-reflection. I became aware that I was beginning to feel guilty. This guilt was connected to my having repeatedly provided this 'summary' of the week for her, and that by doing this I had been, in some way, 'overprotective'—doing something for her to save her from the difficulty of doing it for herself, and, perhaps, also protecting myself from her anger and from my own sense of failure at the long stalemate. But then, I reflected to myself, I had, at the time, considered all these possibilities and had decided that it was the best choice under the circumstances.

My second example has to do with the best *use* to be made of my own emotional responses. Here is an everyday example of this: the patient, a young man in the first stages of his professional work in one of the helping professions, discovered that in his previous training placement he had been given some ambivalent references which called into question his suitability for his chosen profession. My initial reaction was one of identification with his feeling of shock and humiliation at this discovery. But my feelings began to change as the hours went by and he became increasingly angry, projecting more and more viciousness on to the people from whom he had received the bad references, feeling that they must be full of malevolent glee in their persecution of him, and assuming that I probably agreed with their views. Along with my initial empathy, I found myself worried, disappointed and angry that he was not able to contain any of the real pain and anxiety about himself, that he was again resorting to massive projection and blame of others to avoid the pain and conflict about his own abilities.

The recurring dilemma in which I found myself was not so much the question of deciding about my affective response to this, but rather of how to use these emotions in a way which would be the most helpful, for the analysis and the furtherance of his development. Would it be more helpful to remain with him, empathising with his feelings of having been wronged, encouraging him to elaborate his fantasies about his persecutors, or would it be more helpful to be more interpretive and to try and get him into more contact with the kind of projection he was employing to avoid the inner psychic pain?

What I am describing here is, I think, a daily dilemma. It is sometimes described as

the question of empathy versus interpretation. There is a catch here, for the proponents of empathy will claim that an empathic intervention is also an interpretation, whereas those who favour interpretation will say that every interpretation is also empathic. Yet most analysts would agree that there is an issue of potential disagreement here. For the purpose of what I am trying to emphasise, I would say that the question is of whether to function consistently on the basis of identification with the patient, as a selfobject, to use Kohut's term; or, to put it differently, does the patient most need at this moment to feel understood *on his own terms*, to feel that I am close to him, affirming him, holding him, as it were, standing between him and the environment, or would it be more helpful to try and interpret something of his projections and distortions?

It seems to me that the two vignettes I have quoted have a common denominator in terms of the problem they pose for the analyst. Trying to conceptualise the similarity, I would say that in both cases I had to make a decision about the potential *autonomy* of the patient at a certain moment, and that this determined what I said or did. This is perhaps more obvious in the first case. The problem was that the patient could not/would not take on the function of the 'observer', the function of memory, the function of 'caring' for herself—and although these questions were being addressed in the analysis (mostly by me), in the meantime I was continuing to do all sorts of things which I hoped she would eventually be able to do for herself.

The second vignette is concerned with autonomy in a different way. The patient had received a severe narcissistic blow. There was no doubt in my mind at the beginning that I could only be empathic, that for a while he would be all-consumed by this blow and the people who had inflicted it. But, at a certain point, I began to feel that we were getting stuck; as if wanting to say, 'that's enough of that, it's time to move on a bit'. I felt that it was very important for him to look at the real anxiety which the bad references had produced. Also guiding me was the feeling that he could do more than he was doing, and that he needed to be confronted with this.

Analytic dilemmas and parent–child scenarios

What was common to the dilemmas aroused in me by these two cases was that I found in them both a similarity to the dilemmas involved in parent–child scenarios. Before I try to define this similarity, let me say something about the differences. I am not suggesting that there is a similarity between parents and analysts in terms of what they *do* with their children/patients. In providing a holding environment, analysts are not holding patients in the same way that mothers hold babies. Nor is there much similarity between interpretation and the daily work of mothers—which involves teaching, guidance, direction. What makes for similarity between the dilemmas I have mentioned and parent–child scenarios is connected to the idea that both analysts and parents aim to facilitate psychological growth. In order to achieve this they are constantly moving back and forth between two poles. At one pole is the unconditional acceptance of the child/patient, identification with his distress, making it possible for him to feel very close, affirmed, mirrored and often serving as an auxiliary ego for him. At the other pole is the parent's/analyst's vision of the child/patient's potential development as an individual, the facilitation of feelings of separateness, individuation and autonomy.

To take the parallel a bit further into the realm of everyday life: in my first case example, I was serving as an auxiliary ego to my patient for a while, doing something I hoped she would eventually be able to do for herself, but I was not entirely confident that I was not being overprotective. I was reminded of such dilemmas as: should I sit with my child and do the homework together with her, or should I leave her on her own to struggle with the frustration and work it out? Would it be more helpful to give her my hand while crossing over this slippery patch of ground, or will it increase her fearfulness, or perhaps even insult her?

Or, in the second case, my small child is having a temper tantrum over an insult he has received. I want to hug and comfort him, but I also want him to learn to accept that this is part of life. Or, he comes home from school

angry at something the teacher has done; I want to comfort him, but also to help him to see where he has distorted the situation. When is the right time to switch from a purely accepting and comforting role, to a more inquiring, and also reality-oriented one? Again, I am trying to suggest a similarity which is very qualified. This similarity involves the nature of the modality of thought with which we think about this question of facilitating growth at any given moment.

THE DIALECTIC OF GROWTH

One obvious response to this kind of question is that one has to know the full context of the situation, both in terms of the child and the parent, in order to decide how to respond. But what I am trying to do here is to suggest not that there is an ideal answer about how to respond, but that the dilemma itself involves a kind of thinking about growth and development which is fundamentally *dialectic*. This seems to me to be one of the dimensions of psychoanalytical clinical thinking, as well as of 'maternal thinking', to use a phrase coined by the feminist philosopher Sara Ruddick (1989).

Ruddick describes a kind of thinking which develops in connection with the practice of motherhood. Being of the practicalist school of philosophy, she believes that all systems of knowledge develop within a specific context. The context to which she addresses herself is 'maternal thinking'—the system of beliefs, guidelines and practices developed by mothers connected to the aims of childrearing, which are, for her: preservation, fostering of growth, and social acceptability. She describes a mode of thinking and functioning as a mother which is dictated by the above aims. According to Ruddick, some of the main characteristics of maternal thought are: (1) a unique combination of reason and feeling employed, where reason is used to monitor feeling and vice-versa; (2) a quality which I would describe loosely as 'ongoingness'—all ideas about maternal work must be constantly checked *in vivo*, this is why child guidance books are of so little help; (3) the complexity which results from the need both to hold and protect, on the one hand, and to encourage and expect individuation and autonomy, on the other. Mothers should 'hold close' and 'welcome change', 'relish complexity', and 'tolerate ambiguity'.

It seems to me that there is a fundamental dialectic at the basis of all thought and action, which tries to facilitate growth, both by mothers and by analysts. A mother holds, protects, comforts, identifies with her children's distress and tries to provide an atmosphere of safety. This is one swing of the pendulum. She also questions, observes with objectivity, encourages progress, envisions the future. That is the other swing of the pendulum.

Before going on to discuss the similarity with analytic work, let me say that the above remarks taken by themselves may sound like both an idealisation and a simplification of motherhood. This is not my intention, nor do I pretend to do justice to the complexities of motherhood. I am, rather, addressing myself to a mode of thinking which seems to me to characterise the 'good-enough' mother as she interacts with her small child, and to a certain type of dilemma with which she deals all the time. The analytic dialectic, which seems to me to be parallel, is complex and can be described in terms of different pairs of poles between which the analyst moves back and forth. I will mention a few:

(1) *Closeness and individuation.* At times, the analyst facilitates closeness; at times, autonomy and individuation. He does this by virtue of the kind of intervention he employs. Sometimes the two go together; often they conflict. Closeness is often indistinguishable from a feeling of oneness. Often the analyst must decide whether the patient is at a point where this illusion of oneness is necessary for his development, or whether to interpret in such a way that the patient becomes more aware that his feelings are his own, and that what he feels about his analyst may be projection. With my first patient, I let her continue for quite a long time—with my taking on the role of caretaker and observer—without insisting she knew I was doing it. In my second example,

my patient needed me to identify with his anger, to see things exactly the way he did, to join him in vilifying those who had hurt him. At a certain point, I found it necessary to interpret his need for us to feel exactly alike.

(2) *Affirmation and a vision of the future.* The analyst sometimes uses empathy in order to 'feel' himself into his patient's affective state. He accepts the patient unconditionally, with whatever thoughts, feelings and fantasies that he may have. The analyst may say things to which the patient will reply, 'yes, that's exactly what I feel'. At other times, the analyst will make interpretations about the patient's defences. I use the term 'vision of the future' because when the analyst interprets something outside of the patient's immediate awareness, he is, in fact, anticipating the possibility that the patient may reach a broader vision of himself and his options. The analyst thus both *accepts* the patient unconditionally as he is at the moment, and has a vision of possible change and development—even if the analyst has no definite idea about what the change will be.

(3) *Experience-near and accepting the possibility of not knowing.* When analytic interventions are 'experience-near' they remain in the realm of what the patient feels and knows, recognising his thoughts and emotions, giving them credence, allowing their existence. At other times, analysts interpret in a way which tries to facilitate the patient's acceptance of the fact that there are things about himself that he does not know, things which may even feel alien to him when first heard. This also means dealing with the patient's vulnerability at *not* knowing.

(4) *Self and object needs.* So much has been written on this subject that it seems superfluous to expand. What seems relevant to this discussion is that, if speaking of a dialectic, we can say that these needs are sometimes conflicting, and sometimes not. When there is a conflict, it is for the analyst to intervene in a way that makes it possible to navigate between the poles.

These pairs, and there are surely others, are all connected to the dialectic of growth. The analyst moves between these poles, sometimes in an easy, flexible way, but at times the movement itself becomes the issue.

OBJECT RELATIONS—HOLDING AND CONTAINING

The idea of a parallel between the psychoanalytic process and the mother–child relationship has a long history in psychoanalysis. But such parallels are the exception rather than the rule in early psychoanalytic writing:

> I cannot advise my colleagues too urgently to model themselves during psycho-analytic treatment on the *surgeon*, who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skilfully as possible (Freud, 1912, p. 115, my italics).

> The doctor should be opaque ... and, like a *mirror*, should show ... nothing but what is shown to him (Freud, 1912, p. 118, my italics).

Freud's best known images for the psychoanalyst were that of the *surgeon* and the *mirror*; the surgeon image suggests an alignment with the medical profession, with scientific—i.e. positivist—knowledge, with detachment, with the idea of one person 'operating' on the other, with the division of roles, doctor and patient; the 'mirror' implies objectivity, neutrality, observation, and the idea that the analyst does not 'put in' other than that which is already there. These associations have become commonplace.

Of these two images, the 'surgeon' has more or less disappeared. It would seem that the emotional detachment implied by the image is no longer considered valid by any school of psychoanalysis. The 'mirror' image, on the other hand, has been, in a certain sense, transformed, in the hands of Winnicott and, principally, Kohut (see Kohut, 1971). But the logical basis for the comparison has changed. When Freud compared the psychoanalyst to a mirror he was stressing the objectivity, or neutrality, common to both. With Winnicott, but mainly with Kohut, the objective,

neutral mirror has given way to the mirror–mother, an image which describes the early and archaic function of the mother in acknowledging, affirming, accepting and enhancing the self-image of the child.

A gradual shift seems to be taking place over the years. The emergence of object-relations theory on to the centre of the analytic stage has made transference and countertransference very central. It has also aroused many discussions about what analysts do besides interpretation; discussions which try to understand more about the curative elements in psychoanalysis. Empathy has received much attention, and the concepts of *holding* and *containing* have come into common use. Both these concepts are used by the theoreticians who initiated their use, Winnicott and Bion, to describe both something which happens at the beginning of life in the primary relationship between mother and child, *and* to describe certain aspects of the analyst–patient relationship which are thought to be analagous to the former. In speaking of the holding function of the analyst, Winnicott says:

> Psycho-analysis as we learn it is not at all like child-care. In fact, parents who interpret the unconscious to their children are in for a bad time. But in the part of our work as analysts that I am referring to there is nothing we do that is unrelated to child-care or to infant-care. In this part of our work we can in fact learn what to do from being parents, from having been children, from watching mothers with very young babies or babies unborn (Winnicott, 1963, pp. 251-2).

Winnicott described holding as the first stage in the life of the mother-and-infant unit; in which the mother has the entire responsibility for providing for the safety and needs of the baby, who has few means of communicating its needs, where the mother stands between the baby and the environment in order to protect the baby. But the term is also used for the continuation of this function in moderate form as it is carried out all through childhood and adolescence. This later aspect of holding has been described by Khan (1963).

Speaking of analysis, Winnicott uses the word *holding* with different connotations. In one place he says:

> the analyst is *holding* the patient, and this often takes the form of conveying in words at the appropriate moment something that shows that the analyst knows and understands the deepest anxiety that is being experienced, or that is waiting to be experienced (Winnicott, 1963, p. 240).

This statement of Winnicott's could actually apply to interpretation as well, and, indeed, Winnicott says more than once in his writing that a correct and well-timed interpretation in analytic treatment gives a sense of being held physically that is more real than if real holding or nursing had taken place. At other times, Winnicott uses the word *holding* to describe the necessity to wait, not to interpret, and to let the patient find himself. What seems to be common to these statements is an emotional attunement to the patient, which is felt by the patient to be protecting and thus holding, in the symbolic sense of the word. We could also say that there is an assumption that the analyst is *caring* for the patient as well as treating him. The loose, and sometimes seemingly contradictory thoughts evoked by Winnicott's statements about holding leave a creative space for the individual analyst to pursue his own thoughts on the matter.

Winnicott speaks of holding as an *environmental* provision, but goes on to say:

> This is not to say, however, that the ill-effects of such failure [i.e. the failure in holding] cannot be described in terms of ego distortion and of the defences against primitive anxieties, that is to say, in terms of the individual. It will be seen, therefore, that the work of Klein on the splitting defence mechanisms and on projections and introjections ... is an attempt to state the effects of failure of environmental provision in terms of the individual (Winnicott, 1965, p. 50).

This last statement by Winnicott leads us directly to a discussion of *containing*, a Kleinian concept developed by Wilfred Bion (1959, 1962). As with the concept of *holding*, *containing* refers both to a developmental process from the beginning of life, and, analogously, to a

process which goes on in analysis. The baby has no means with which to deal with its distress, which is always threatening to overwhelm him, to become 'catastrophic' in Bion's terms. The only way he can deal with it is to get rid of it, project it on to the mother. According to Bion, the infant projects part of his psyche, especially his uncontrollable emotions, on to the mother, or into the 'good breast', which serves as a container; the container, or the mother, detoxifies them in a way that they can then be reintrojected by the infant and eventually become thoughts. Thinking, then becomes a means for dealing with distress. The mother's part in this is her ability to accept the initial distress, and to transform the projected feelings of the baby from bad to good, or at least to tolerable. Bion calls this transformation *reverie*. The mother engaged in reverie is receptive and metabolising. In its optimal form, this procedure is an integral part of normal development.

In the analytic situation, *containing* implies being the recipient of the patient's projective identifications and being able to deal with them in such a way that they may be reintrojected by the patient. The technical questions of how to do this are very broad and basically unresolved, and perhaps unresolvable, as they concern the personal style of the individual analyst. They involve issues of timing, tact, ability to gauge the patient's affective state, and the ability of the analyst to stand being in a very uncomfortable position.

The emergence of these images, holding and containing, although each stems from a different theoretical orientation, is a natural outcome of the development of object-relations theory, which has come to be widely accepted *in one version or another* by all or most theoreticians and practitioners of psychoanalysis. This is not to minimise the differences between the various theories, but rather to emphasise a general trend, a shift in emphasis, which seems to transcend individual differences.

What has emerged, as a result of this, is an analogy between the mother–child relationship and that of the psychoanalyst and his patient. The expression *mother-analyst* is used in a matter-of-fact way by analysts of widely diverging theoretical persuations. This *mother-analyst* analogy would seem to imply an emphasis on the protective—nurturing—caring elements within the psychoanalytic process, although, again, these elements may be interpreted differently in different theoretical contexts.

The analogy also implies something about the *developmental* aspect of the psychoanalytic process and of psychoanalytic technique. What I am stressing is that the technique used by the analyst has a developmental aspect, i.e. it takes into account where the patient is, developmentally, and how much he can do, in terms of his partnership, in the analysis; in this sense it bears a resemblance to certain aspects of parental strategies. The strengthening of this parallel again seems to me the direct outcome of the emergence of the primacy of early object relations in human development. The emergence of early regressive needs in the analytic situation has also brought the analyst into more direct contact with his or her own maternal feelings.

OBJECT RELATIONS AND THE CORRECTIVE EMOTIONAL EXPERIENCE

This tendency to find an analogy—albeit symbolic—between the analytic situation and the mother–child relationship makes it possible to look more tolerantly, and with less indignation, at the much-maligned idea of the 'corrective emotional experience' (Alexander, 1949). It is not difficult to understand the indignation that this idea aroused at the time. Alexander's self-proclaimed use of manipulation harked back to the early practices of suggestion, which had been abandoned by Freud in the search for a method that would produce intrapsychic and more lasting change. However, this reaction made it difficult to address the question of a truly corrective emotional experience, which is inherent to the psychoanalytic process.

Much has been written in recent years about the question of which is more curative, the relationship in psychoanalysis or insight? To do justice to the subject it would be necessary to go into more preceise definitions. But, even using these rough concepts, we may say that

this 'relational' aspect, which implies some kind of corrective emotional experience, is considered much more important than it was fifty years ago. This becomes very clear if one compares the symposium which took place in 1988 under the auspices of the American Psychoanalytic Association, and was published in the book *How Does Treatment Help?* (Rothstein, 1988), with a similar symposium published in the *International Journal of Psycho-Analysis* in 1939. Comparing these two symposia, one becomes keenly aware of the historical pendulum in motion, alongside the personal hour-to-hour pendulum of each individual analyst.

Although the 'relational' elements have always been part of psychoanalytic technique, they remained for decades without strong theoretical emphasis. An exploration of the reasons for this would be interesting and is beyond the scope of this paper. However, it seems plausible, as suggested by Theodore Jacobs (see Rothstein, 1988), that in its early years psychoanalysis, innovative both in theory and method, tended to put aside those elements which were common to other kinds of treatment. Freud wanted to distinguish psychoanalysis both from other therapies and also from other forms of guidance. The result was an idealisation of insight as the primary, or even sole, curative factor in psychoanalysis.

I would like to point out what seem to me to be some of the central factors involved when one speaks about this new version of the corrective emotional experience.

The first element is that of the actual elements in the analyst's technique which are reminiscent of an idealised maternal holding environment. Modell enumerates these as the following:

> the analyst is constant and reliable; he responds to the patient's affects; he accepts the patient and his judgment is [usually] less critical and more benign; he is there primarily for the patient's needs and not for his own; he does not retaliate; and he does at times have a better grasp of the patient's inner psychic reality than does the patient himself, and therefore may clarify what is bewildering and confusing' (Modell, 1976, p. 291).

The analyst is *there* for the patient, during the analytic hours, and sometimes beyond, in a way that the mother is there for the infant—what Winnicott calls 'primary maternal preoccupation' (Winnicott, 1956).

Another factor inherent to the 'corrective emotional experience'—which is, in a way, a correlative of the first—is the idea of the analyst being a *new object* for his patient. Alexander used this concept, advocating manipulative techniques in which the analyst consciously assumes a role different from that of the real parent, in order to make corrections of faulty parenting. Other psychoanalysts have come to recognise that there is a deeply curative element in this new opportunity to have a *new* and *different* kind of 'trial' object-relationship, without 'assuming a role' (Loewald, 1960; Chused, 1982). Loewald, in speaking of the analytic relationship, says,

> The parent–child relationship can serve as a model here. The parent ideally is in an empathic relationship of understanding the child's particular stage in development, yet ahead in his vision of the child's future and mediating this vision to the child in his dealing with him. This vision, informed by the parent's own experience and knowledge of growth and future, is, ideally, a more articulate and more integrated version of the core of being that the child presents to the parent. This 'more' that the parent sees and knows, he mediates to the child so that the child in identification with it can grow. The child, by internalizing aspects of the parent, also internalizes the parent's image of the child (Loewald, 1960, p. 229).

What Loewald does not discuss is the difficulty of the parent and the analyst in fluctuating between the empathic understanding of which he speaks, and this 'vision of the child's future'—the questions of how the parent, or analyst, evaluates both the need and the good of the patient at any particular moment. Nor does he discuss a possible contradiction between these two: the empathic relationship of understanding, and the vision of the child's future. The cues are often confused. Concerning the question of whether the child, or patient, is ready to go further, to see a bit more, it is often difficult to make a differentiation between 'I can't' and 'I won't'. Thus, the dialectical movement which I am describing is

often difficult and turbulent, rather than an easy and natural flow.

The analyst is, in the above sense, a new object, and one may say that, because of this, the relationship is different from the patient's early relations with his primary love-objects, his parents. This does not mean that the analyst is 'trying' to be different, or, indeed, that he is doing anything manipulative or active to be different. Let me try and illustrate this from my clinical vignettes.

In the case of a young woman who seemed unable to assume any of the caretaking functions I mentioned, let me give some additional background of the analysis. In the first stage of the analysis, a long period which preceded the period of the dilemma which I have described, my patient was very cold, detached and negativistic. She spoke very little, told me very little about her life; what she did tell me was so disjointed that I spent a lot of time trying to figure out what had been happening in the empty spaces. For instance, she would tell me about a period of coldness towards her husband but without giving me any idea of the cause, of what had preceded it. Then, after telling me about it in the hour, it would disappear from the stage. I became more and more discouraged about the possibility of having an analysis; and then we had a rather long period of confrontation during which she brought up the possibility of changing the form of the treatment and continuing in the form of a twice-a-week, face-to-face therapy.

I used to say to myself that with this patient, the secondary processes had somehow become 'hypertrophied'; this expressed itself in her seemingly total inability to consider anything that was not rational, controlled, detached and concrete. At the same time, she attended the analysis scrupulously, never missing an hour, never even asking to change an appointment. When I tried to discuss with her what she was seeking in analysis, her responses were so blurred and roundabout that I cannot even recall them. It became obvious to me that something was bringing her to analysis, something very strong, almost in spite of herself, and that any information about this was, in fact, unavailable to her. In my mind I had the idea that the analysis was a kind of safety-net she was using because, in some deeply recessed part of her mind, she knew she was in danger.

In the background was my knowledge of her history—the oldest child in a family in which her brother had been born 11 months after her. Without going into this further, I had reason to hypothesise, and this hypothesis was supported by other, although rather meagre, information about the family—that she had literally done away with all her neediness, infantile wishes, sense of being ousted, and had somehow managed to develop into this cool, rational and self-possessed young woman.

The second stage, that described in the first part of my paper, was in many ways similar to the first. My patient was still speaking in a very constricted way, providing less information than I needed in order to understand what was going on, allowing herself hardly any play of thoughts and fantasies. There were slightly longer periods of 'letting herself go'—i.e. talking about things that had happened to her without immediately bringing herself up short with expressions like 'how ridiculous to be talking like this'. I also felt that she was listening to me more, taking something in, and that what she was taking in was having some effect—as I mentioned previously, in helping her to resume the analysis more easily after the weekend break.

As for my own feelings, I increasingly thought of her as a very small child, almost a baby, who had been forced to develop this very precocious 'crust'. In this sense, I was feeling like an alternative to what I imagined about her real mother, who, it seemed to me, had been unable, for whatever reason, to deal with two babies, and had thus helped one of them turn into a 'big girl'.

Technically, the problem was how to deal with her forgetfulness, her breaking of links, and her inability, or refusal, to 'worry' about what was happening in the analysis. Looking back, I think that my decision to take on these functions for quite a long time must have been influenced by the feeling that, in some sense, this was her way of 'giving up control'—the only way she could give up control was to become very passive, letting me do everything for her. I think that one of the things that determined the way I handled the analytic

situation at this time was connected with the image I had of her mother; this image was conveyed to me by certain things I felt about her—she herself never referred to this aspect of her mother—as someone who had in some way abandoned or rejected needy aspects of the baby too quickly and too early. I think that in helping her to remember and connect, I was allowing her to *be* that dependent baby, the dependence being acted in in the analysis by not being able to take much of an active part in the work.

This decision, on my part, was not unambiguous. As time went on, my patient did not take on this function for herself, and I began to worry that I had made a mistake, that in doing too much for her I had spoiled her chances of learning to do it by herself. In addition, I also recognised that in this inability to take on any of the caretaking functions for herself, there was a controlling element. But it was clear that, in this particular segment of the analysis, I had recognised that what was needed was more support of my patient's 'baby' needs, and as the analysis went on, I felt that perhaps I had made a mistake in allowing this situation to become too prolonged. I believe that this feeling of having made a mistake is inherent to the basic dilemma I am discussing. For a while, I used a technique which recognised my patient's helplessness as genuine growth, away from the pseudo-precocious crust she had developed, probably very early in her life. My doubts re-emerged at a time when it was really necessary to examine the possibility of going a bit further; staying more with the 'vision of the future', to use Loewald's expression.

In my second example, that of the young man who became more and more entrenched in his anger, at the beginning I had the feeling of being with a small child who had received a terrible blow and was reacting by having a temper tantrum, and I felt that the most helpful thing would be to be with him and 'hold' him—by recognising his distress and disappointment. In the course of the hours which followed, I felt that I had been turned into a bad object by his projections, and that his escalating anger had in fact made *me* the helpless one, that, in fact, two things were happening at the same time: he was both projecting his anger on to me (in the sense that he had decided that I, in my anger at him, was delighted that he had been criticised by other therapists), but also, by so doing, a situation had been created where I could be of no help to him, for the moment. I was being pulled and pushed by two feelings: to hold him, remain close to him, until there was more of a 'sign' from him that he was ready to let go of some of the projections with which he was protecting himself, or to try and pull him forward, and to try to convey to him —through interpretation—a more 'adult' view of what was going on.

In the background was my feeling, from things which I had learned from him, that his tempter tantrums had been dealt with by his mother with a kind of cuddling, but that she had, at the same time, been terrorised by them. At a certain point, they had shifted from being expressions of real distress to a kind of manipulativeness, which had brought her to indulge him, leaving her rather helpless in the process. In choosing to interpret more, rather than simply hold him in his anger, I was again behaving differently from his over-indulgent, terrorised mother.

In neither case was I trying to be different from the parents of these patients. However, my tendency to be more empathic with the first patient and more interpretive with the second (in these particular phases of the work) stemmed, I think, from the feeling that each patient needed more of one or the other, in order to have a better opportunity for an optimal balance between closeness and individuation, affirmation and a future-oriented vision. It was neither a dose of empathy nor of interpretation that was needed, but a chance to experience moving more flexibly *between* them. Again, these are small sections from the analyses and the need for balance was different at other times. This relationship with a person, the analyst, who provides an opportunity for this optimal dialectic movement is, I believe, one of the curative elements in psychoanalytic treatment. How to facilitate this balance is an hour-to-hour dilemma for the analyst.

These kind of dilemmas often come up in supervision and in technical and clinical seminars. As one grows older in analysis, one tends to evolve a style, or an approach, which is the product of many factors: the character of the analyst, his identifications with his own analyst and supervisors, the personal history of his clinical work, his '*Weltanschauung*', his reading. One of the interesting questions is that of the differences between analysts in their approach to these dilemmas. These differences can be accounted for in several ways, e.g. one speaks of the style of the analyst, which is a general way of speaking about these individual differences.

An interesting way of looking at these differences has been suggested by Carlo Strenger (1989), who suggests that psychoanalytic schools differ in regard to the degree of optimism or pessimism with which they regard human nature (corresponding to the romantic and classical views of nature). What the analyst does and says is determined by the degree of optimism, which says that man's nature is basically good and will develop well if left to unfold, or pessimism, which claims that man's basic nature must be tamed. Empathy is seen as being more suitable for the first approach; interpretation for the second.

Another way of looking at the differences between the way analysts work in this regard is through that of *character* differences between analysts. This has been discussed in detail by Francis Baudry not only in regard to the questions I raise in this paper but in regard to analytic functioning in general (Baudry, 1991).

I would agree with both these views, both that the individual character of the analyst determines to a great extent the way he approaches the kind of dilemmas I have mentioned, and that there is the relevant question of a basically optimistic or pessimistic approach to human nature.

I am trying to say, in addition, that the analyst's approach to these questions is very much connected to his own inner experience of being a child, of being parented, and the kind of inner imago of the good parent which has evolved from this. This imago may take the form of being more or less permissive or severe, a need for consistency, a need for perfection, to mention just a few.

That these are very crucial issues for analysts is borne out by the vehemence of the discussion that goes on between them about these issues—but that is beyond the scope of this paper.

From the beginning, the development of psychoanalytic meta-theory and the development of the theory of technique have gone hand in hand. There has always been much debate about the advantages and disadvantages of this or that technique. The classical approach to technique involved the use of free associations, the complementary use of the analyst's free-floating attention and neutrality, the use of interpretation as the primary form of intervention. Concomitant with this there have always been questions, alternative suggestions about technique, and uncertainty. I believe that there is an important similarity between the uncertainty of psychoanalysts and the uncertainty of mothers in the process of bringing up children. Mothers are often anxious about the possible results of different ways of dealing with their children. I believe that this is true of analysts as well—this must be so, because one is dealing, in both cases, with human development which is full of unknowns and uncertainties. The search for a clearly defined either/or technique in psychoanalysis is one way of dealing with this anxiety-producing uncertainty, but not a very fruitful one.

We have certain guidelines for conducting an analysis, but these guidelines contain a great many possibilities for variations in technique, all falling within the realm of what is commonly considered to be 'analysis'. We also have no research instrument that makes it possible to evaluate the relative merits of one form of technique as opposed to another. I believe that there is an uncertainty, an *existential* uncertainty about the course of human development that gives rise to a perpetual and on-going search for more competence. The search for analytic competence is very much like the search for maternal competence; both are constantly evolving, both involve a certain

amount of trial and error, and both deal with the dialectic movement which is involved in facilitating growth.

SUMMARY

This paper makes a comparison between a certain type of dilemma facing the analyst in his daily decisions about how to intervene and what to interpret, and the dilemmas faced by parents concerning what would be most useful, at a particular moment, in facilitating the growth of their children. Both analytic and parental strategies move back and forth between empathic closeness and support, on the one hand, and more objective understanding—involving a 'vision of the future'—and facilitating individuation, on the other. The manner in which these strategies are used is *inherently dialectic*, and, one hopes, suited to the child's or patient's needs, but also depends on the style of the analyst. This similarity between the work of analysts and that of parents (assuming, of course, the basic *differences* between these two vocations!) is congruent with the growing prevalence, in almost all contemporary psychoanalytic thought, of object-relations theory.

TRANSLATIONS OF SUMMARY

Cet article établit une comparaison entre un certain type de dilemme auquel est confronté l'analyste dans ses décisions quotidiennes, concernant la manière d'intervenir et ce qu'il faut interpréter, et les dilemmes des parents en ce qui concerne ce qui serait le plus utile, à un moment donné, pour faciliter le développement de leurs enfants. Les stratégies analytiques et parentales ont toutes deux un mouvement de va et vient entre d'un coté, une intimité empathique et un soutient, et de l'autre, une compréhension plus objective comprenant 'une vision du futur', et facilitant l'individuation. La manière dont sont utilisées ces stratégies est en soi dialectique, elle se veut adapter au besoin de l'enfant ou du patient, mais elle dépend aussi du style de l'analyste. Cette similitude entre le travail de l'analyste et celui des parents (étant conscient, il va sans dire des différences fondamentales entre ces deux vocations) est conforme à la prédominance croissante de la théorie de la relation d'objet dans presque toute la pensée psychanalytique contemporaine.

Dieser Beitrag vergleicht eine gewisse Art von Dilemma, von der der Analytiker in seinen täglichen Entscheidungen über die Art der Intervention und die Frage, was interpretiert werden soll, konfrontiert wird, und Dilemmas hinsichtlich dessen, was zu einem bestimmten Zeitpunkt dem Wachstum ihrer Kinder am dienstlichsten ist, von denen Eltern konfrontiert werden. Sowohl die analytischen, als auch die elterlichen Strategien schwankenzwischen emphatischer Nähe und Unterstützung einerseits, und befähigender Individuierung andererseits. Die Art, auf die diese Strategien angewendet werden, ist inhärent dialektisch, hoffentlich für die Bedürfnisse des Kindes oder Patienten geeignet, hängt aber auch vom Stil des Analytikers ab. Die Ähnlichkeit der Arbeit des Analytikers mit der der Eltern (wobei selbstverständlich die Differenzen zwischen diesen beiden Tätigkeiten angenommen werden) ist kongruent mit der wachsenden und nahezu ausschließlichen Prävalenz der Objektbeziehungstheorie im zeitgenössischen psychoanalytischen Denken.

Este artículo hace una comparación entre un cierto tipo de dilema con el que se enfrenta el analista en sus decisiones diarias sobre cómo intervenir y qué interpretar, y los dilemas con los que se enfrentan los padres respecto a qué es lo más útil en un determinado momento para ayudar al crecimiento de sus hijos. Tanto la estrategia analítica como la paternal oscilan entre enfático apoyo y acercamiento por un lado, y por otro una manera más objetiva de comprender, con 'una visión de futuro', para facilitar la individualización. El modo en que se usan estas estrategias es *inherentemente dialéctico*, idealmente apto para las necesidades del niño o el paciente, pero también condicionado al estilo del analista. La semejanza entre el trabajo de analistas y el de padres (siempre teniendo en cuenta las *diferencias* básicas entre estas dos vocaciones) es congruente con la creciente prevalencia en casi todo el pensamiento psicoanalítico contemporáneo de la teoría de las relaciones de objeto.

REFERENCES

ALEXANDER, F. (1949). *Fundamentals of Psychoanalysis*. New York: W. W Norton, 1961.

BAUDRY, F. (1991). The relevance of the analyst's character and attitudes to his work. *J. Amer. Psychoanal. Assn.*, 39: 917-938.

BION, W. R. (1959). *Experiences in Groups*. London: Tavistock.

—— (1962). *Learning From Experience*. London: Heinemann.

CHUSED, J. (1982). The role of analytic neutrality in the use of the child analyst as a new object. *J. Amer. Psychoanal. Assn.*, 30: 3-28.

FREUD, S. (1912). Recommendations to physicians practising psycho-analysis. *S.E.* 12.

JACOBS, T. (1988). Notes on the therapeutic process: working with the young adult. In *How Does Treatment Help?*, ed. A. Rothstein. New York: Int. Univ. Press.

KHAN, M. M. R. (1963). The concept of cumulative trauma. In *The Privacy of the Self*. New York: Int. Univ. Press, 1974, pp. 42-58.

KOHUT, H. (1971). *The Analysis of the Self.* New York: Int. Univ. Press.

LOEWALD, H. (1960). On the therapeutic action of psychoanalysis. In *Papers on Psychoanalysis.* New Haven: Yale Univ. Press, 1980, pp. 221-256.

MODELL, A. H. (1976). 'The holding environment' and the therapeutic action of psychoanalysis. *J. Amer. Psychoanal. Assn.*, 24: 285-307.

ROTHSTEIN, A. (ED.) (1988). *How Does Treatment Help?* New York: Int. Univ. Press.

RUDDICK, S. (1989). *Maternal Thinking.* New York: Ballantine Books.

STRENGER, C. (1989). The classic and romantic vision in psychoanalysis. *Int. J. Psychoanal.*, 70: 593-608.

WINNICOTT, D. W. (1960). The theory of the parent-infant relationship. In *The Maturational Processes and the Facilitating Environment.* London: Hogarth Press, 1965, pp. 37-55.

—— (1963). Dependence in infant-care, in child-care and in the psycho-analytic setting. In *The Maturational Processes and the Facilitating Environment.* London: Hogarth Press, 1965, pp. 249-260.

—— (1963). Psychiatric disorder in terms of infantile maturational processes. In *The Maturational Processes and the Facilitating Environment.* London: Hogarth Press, 1965, pp. 230-241.

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