Child-Therapy Clinic, and was a valuable member of the Clinic's staff. Having thought through a particular issue and arrived at an opinion, she would stand by it, sometimes in the face of considerable pressure. We came to rely on her judgements, and her status within the Clinic was unique. She could be critical, even dismissive, if she felt that a student or a colleague was not giving their best, but this attitude was based on the high standards she set for herself. She possessed considerable wisdom and held authority without authoritarianism.

The Association's debt to Ruth Thomas is great. She played a major part on the various working parties set up to consider acceptable standards for child psychotherapists and was involved in drawing up a document on training. This work resulted in the formation in June 1949 of the Provisional Association of Child Psychotherapists (Non-Medical). Ruth subsequently shared in the onerous task of vetting the foundation members of the Association and also of assessing the existing Training Schools by the standards that the Association had laid down. She continued to give outstanding support to the Association during its early, and sometimes difficult years.

When her sight became seriously impaired, she felt unable to continue in active professional work, and returned to Australia where she had life-long friends. In 1981, when she became seriously ill, she decided to return and spend her last months near her many English friends. Her last illness, which was protracted, gave us the opportunity to show her what she meant to us. She will be mourned by many people.


PROBLEMS IN THE USE OF THE COUNTER-TRANSFERENCE: GETTING IT ACROSS
ANNE ALVAREZ, London

As work in the counter-transference is so closely linked with work in the transference, it may be useful to comment on some developments and difficulties in the notion of transference. In Freud's earliest thinking, in the Studies on Hysteria, and in the Dora case, the transference is seen mostly as an obstacle, a resistance, a symptom to be removed, decontaminated (1895d) (1905). Gradually it changes. What starts, in the Studies on Hysteria, as a transference of a woman's compulsive wish for a kiss, and is consistent with libido theory, changes by the time of the Wolf Man to a transference on to Freud of the wish to have the love (frequently it is still only the sexual love) of a valued father (1918). The gradual humanization of Freud's general conceptual structure was accompanied by a major change in his view of the source of the forces of repression. Thus, in The Ego and the Id, the controlling, restraining forces are no longer seen as issuing from external reality, as a sort of lid on the cooking pot, but as a conscience speaking with a human voice to the child in the patient (1923).

Melanie Klein pushed the humanizing process even further in her study of the very primitive superego in paranoid and depressive psychotic patients and in very young children (1955). She found scattered human elements existing in piecemeal form in what appeared to be phantasies of the most inhuman forces and objects. In this light a fascination with fire or electricity, a sensual attachment to a velvety fabric, say, would be seen as representing not only sexual impulses of the patient, but also the imagined sexual and sensual qualities and powers of his parents, or parts or aspects of his parents. Object relations theory, and especially part object relations theory, and even more especially, split object relations theory, do extend the arena in which the transference can be seen to be played out. For example a psychotic patient of mine used to reach with his arms and his whole body towards me, or sometimes only with his gaze, in a manner that Frances Tustin has called "entangling". It was indeed very entangling. It felt loving, harmless, gentle, but unbelievably enveloping. It felt not human, not even animal, but more like the infinitely slow but inexorable growth of a plant. At times I felt he must be brain-damaged; this wasn't human — this was vegetable love. In fact, I came to see that he seemed to be using his whole body as a sort of giant tongue, and to sense that I was simply some giant object for licking — a sort of nipple-less breast, perhaps. He used his eyes in the same manner, for licking instead of looking.

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There are two further developments following from the work of Mrs. Klein to which I wish to draw attention. The first is her emphasis on the importance of the negative transference, and the second is her concept of projective identification. In her paper, *The Origins of Transference*, she concluded that transference arises from the same processes which originate early object relations, namely, the primal processes of projection and introjection directed towards their first object, the mother's breast. She declared that the introjection of the mother's breast is the beginning of superego formation (1952).

The infant observation studies initiated by Mrs. Bick and the recent flood of Child Development research would encourage us to add: the mother's smell, arms, lap, voice, touch as equally vital elements in the building up of this early introjected object (1964) (Macfarlane, 1977). The point, in any case, which Klein is making, concerns a theory of the origins of transference, its clinical history, as it were. There are considerable differences among Kleinian analysts and Kleinian psychotherapists today in the manner and pace with which they would introduce part-object *language* into an analysis. I happen to think myself that this is not only a technical issue, it's a theoretical one which connects with Bion's notion of alpha function (1962), Segal's view of symbol formation (1957), and Meltzer's view of reconstruction (1981), but space does not permit discussion of this issue here (Alvarez, 1981).

Klein then goes on to make her rather revolutionary and still controversial technical point about the advances in technique which follow from the recognition — in work with young children, but also with schizophrenics — that we are unable to penetrate to what she called the deepest layers of the mind without analyzing the negative transference alongside the positive. I want to stress the last three words, "alongside the positive", because I think it's important to notice their presence (1952). In a paper called *Developments from the work of Melanie Klein* (1983), Elizabeth Spillius suggests that both Klein and her followers have often been accused of overemphasizing the negative. Spillius says, and I quote, "Certainly Klein was very much aware of destructiveness, of defences against it, and of the negative transference, but she also stressed, both in theory and in practice, the importance of love, the patient's concern for his object, of guilt and of separation. Further, in her later work especially she conveys a strong feeling of support to the patient when negative feelings were being uncovered". Spillius says that it is her impression that Mrs. Klein was experienced by her patients not as an adversary but as an ally in their struggles to accept feelings they hated in themselves and had had to deny and obliterate. She goes on: "I think it is this attitude that gives the feeling of 'balance' that Hanna Segal says was so important in her experience of Mrs. Klein as an analyst". In this respect, then, says Spillius, some of the authors of the early Institute of Psychoanalysis membership papers took a step backwards from the work of Klein herself. Spillius got hold of and studied a large number of membership papers at the Institute from the 1950s, '60s and '70s and found that in the '70s destructiveness began to be interpreted in a more balanced way. She suggests that there has

been a change, not in the emphasis on death instinct and destructiveness, but in the way it is analysed — with less confrontation — more fine differentiations. She thinks the change has developed from several sources: from Bion's emphasis on the normality of certain forms of projective identification, which has been further elaborated by Rosenfeld in his stress on projective identification as communication, and from Joseph's emphasis on the need for the analyst to avoid joining the patients in sadomasochistic and other forms of acting out, e.g. becoming a scold or a moralizing judge. She suggests other sources as well. The change, I think, can also be seen in a quite urgent statement by Money-Kyrle. He states in his paper, *On Being a Psychoanalyst*, that Bion's work has made it easier but very important for us to distinguish between a desperate projective identification and a destructive one, or, he says, as both forms may occur together, to see which was the predominant one. He adds, "I believe (though not with certainty) it is both easy and terrible to mistake a desperate projection for a destructive one. For by this means, I think, the beginnings of a constructive link between patient and analyst may be destroyed" (1977).

I think that a change away from the interpretation of destructiveness also arises from the work of Bick, Meltzer and Tustin with autistic children. All of these write in their different ways suggest a failure to achieve projective identification on the part of these children, and stress that lack of integration rather than destructive disintegrating processes plays a part in their psychopathology. All three also hint at possible failure in the containing aspects of the maternal object (1968) (1975) (1972) (1981). The concept of the container is Bion's, and Spillius suggests that through this concept, Bion has made the external object an integral part of the system (1962). She says his formulation shows not just that the environment is important but how it is important. I would say: one of the ways in which it is important. I would suggest that the containing function is only one maternal function among many, and only one analytic function among many.

I want to say a little more about the transference before coming on to a second further development of Mrs. Klein's, that is her concept of projective identification. But first, I want to point out that the Kleinian broadening of the theory of the transference to which I have referred does not make the work easier. If anyone, or anything in the patient's material, e.g. concerning his outside life, or anything in the room can be seen to be connected with earliest feelings and earliest objects, but also to be connected to the person of the therapist, then the job of selection is enormous. I think some critics of Kleinian work in the transference assume a very mechanical process of interpreting every tiny piece of material as referring directly to the person of the therapist. This would mean always interpreting the object to the neglect of the ego or the id. This type of "me-me-me" interpretive work would be a bad mistake with any patient — a phantasy may need room and space to develop, to breathe, and take shape — but is especially dangerous with claustrophobic or confused patients who need help in finding themselves. Adolescents are
good example, because they are often both claustrophobic and confused, and so cannot take in a surfeit of interpretations about dependence on the maternal object, whereas they may respond when some of the interpretations refer to a more responsible bit of themselves or even a belief or a principle which they hold dear. A similar problem arises with autistic children who can become so easily overwhelmed by the power of the object when they are in an opened-up state, that they may retreat further if the need to be inviolate is not understood. Stress on work in the transference need not mean that every interpretation has to refer to the person of the therapist and it need not mean becoming a nag.

Yet even without this difficulty, the selection problem is still enormous. If what may be brought into the transference and put on to the person of the therapist are not only projections of parts of the patient’s self, but also the whole of his inner world, including his objects, split or in parts, past or current, how is one to make the correct choice? Suppose an adolescent patient says to us, “You look tired today”, or a younger child holds up the mother doll and says, “She just can’t sit up today”. Is this a realistic perception achieved by a child who is learning to see what he sees — we do look tired — or is this a direct projection of an exhausted drained aspect of the patient himself? Or is this a consequence of the patient’s greedy demands on us earlier in the session? Or, alternatively, is this an attempt by him to elucidate and give form to a damaged drained internal object which is normally quite repressed? Objects, not only impulses, can be repressed. Joseph’s view is that in the latter case, the patient may be just beginning to try to represent and explore a denied inner world, and so it would be premature to interpret and search out, or even to assume the existence of, attacks which may have led to such a drained object. She believes that one of the things Bion meant by analytic containment was not to push back this type of projection too quickly (1978).

I have often thought it was interesting that Klein does not mention the counter-transference in her paper on Transference. It was after all written in 1952, six years after Notes on Some Schizoid Mechanisms, where she described the process of projective identification (1946). Spillius says she did not envisage its use in any form in which it developed among her close colleagues. There was a lovely example of her caution and sanity in this area written by Dr. Segal at the Memorial Meeting for her last July at the Tavistock and quoted by Spillius. A young analyst told Mrs. Klein in a seminar that he felt confused and therefore interpreted to his patient that the patient projected confusion into him — to which Mrs. Klein replied, “No dear, you are confused” (1983).

Nonetheless, Bion’s use of projective identification as a normal process, his idea of the analytic object as container, and Rosenfeld’s concept of the transference psychosis, led inevitably to the view that the psychoanalyst may not only play the part of the patient’s objects and selves in the patient’s mind, but in his own mind too (1962) (1965). The patient may project so skillfully that he may not only feel his therapist is depressed, he may make her become depressed.

Paula Heimann has written a good deal about the transference and counter-transference. In 1952 she wrote about the analytic ideal of the “detached” analyst, and says that she found the literature “does indeed contain descriptions of the analytic work which can give rise to the notion that a good analyst does not feel anything beyond a uniform and mild benevolence towards his patients, and that any ripple of emotional waves on this smooth surface represents a disturbance to be overcome”. Her thesis, on the contrary, is that the analyst’s emotional response to his patient within the analytic situation represents one of the most important tools for his work. His counter-transference, she claims, is an instrument of research into the patient’s unconscious. She thinks that the first view may derive from a reading of some of Freud’s statements, such as his comparison with the surgeon’s state of mind during an operation, or his simile of the mirror. But she makes the very interesting point that Freud himself used the counter-transference as an instrument of research. She says that psychoanalytic technique came into being when Freud abandoned hypnosis, and discovered resistance and repression. When he tried to elucidate the hysterical patients’ forgotten memories he felt that a force from the patient opposed his attempts, and that he had to overcome this resistance by his own psychic work (1952). In a later paper she pointed out that the analytic situation is a relationship between two persons. I quote: “What distinguishes this relationship from others, is not the presence of feelings in one partner, the patient, and their absence in the other, but the degree of feeling the analyst experiences and the way he makes of his feelings, these factors being interdependent” (1960).

It may be important at this point to define the way in which I myself shall use the term counter-transference, and also the ways in which I shall not use it. I will use it to include all the feeling the therapist may have toward his patient. This might include his own unanalysed transference to the patient or a displacement on to the patient from outside, but it would also include feelings put into him by the patient. It would not include a perception of something going on in the patient which is not accompanied by similar or related feeling in the therapist. For example, I would not say that “my counter-transference told me that the patient was depressed”, unless for no apparent personal reason I suddenly felt depressed myself when he was with him. I would prefer to call the former situation empathetic perception. Such perceptions are just as important for picking up previously unrecognized bits of the patient as is the counter-transference.

I wish now to say a little about Bion’s concept of containment. His notion seems to be that if the mother is capable of something he calls reverie, the baby may project his frustrations, rages and fears into her and get them back in a modified form (1962). The second half of the process — the getting back — he later called transformation (1965). He likened this to the activity of the artist, and also to the interpretive activity of the analyst. I would like to
suggest that in fact the process can really be seen to be made up of three phases; the receptive or containing stage when the material first makes its impact, the transforming work which goes on inside the therapist, and the third phase, the interpretive work. It may seem artificial to divide them up, particularly phases two and three, in this manner, but I find it helpful when thinking about how the process varies so greatly with different kinds of patients. Otherwise, I believe the notion of containment can colour and interfere with, and even prevent the effective operation of, the other two functions. Grotstein appears to be thinking along these lines in his book *Splitting and Projective Identification* (1981). He says it is very important to differentiate Bion’s conception of containment from the mirroring mother as denoted by Lacan, Winnicott and Kohut. He believes that containment for Bion was a very active process which involved feeling, thinking and acting. I would suggest that the notion of containment is after all a metaphor with spatial connotations. It makes one think of a hub of a ball, a lap, the mother’s encircling arms, something essentially concave. Grotstein, in his introduction to the Bion Festschrift book, says it is often thought of as a sort of “flexible rubber bag, which expands with the impact of the infant’s projections”, but he adds that Bion’s theory includes a second step, interpretive transformation (1981). The first more concave receptive function is to my mind only one analytic function. The danger is that the spatial metaphor may take over and interfere with the functions of transformation and interpretation. The therapist may then become, not tolerant, but denying, not flexible, but passive.

The God Hermes is the patron of thieves, merchants, travellers, heralds and messengers. Kermode points out in a book on biblical narrative that Hermes is the patron of all interpreters. Thus hermeneutics is the study of the interpretation of texts. Kermode suggests that Hermes must therefore also be the patron of psychoanalysis. “For he is the god of going between: between the dead and the living but also between the latent and the manifest” (1979). He is also the guardian of boundaries and the guide of departed souls to Hades. I invoke him today not just for fun but because, to my mind, Hermes exemplifies a vital part of our work: he is the message or herald whose job is not only to contain in the counter-transference, but also to transform the messages from the patient, and then, thirdly, to get something back across to him in order to help him to feel known.

I would like now to give three clinical examples of some problems in the use of, that is, the communication of, the counter-transference. The first, a very brief one, is a fairly classic example of a patient making use of what I think was a desperate type of projective identification both to evade and communicate terrible hopelessness. Here I will stress that the containing function is most important.

In the second and third examples less containment and receptivity is required but the message is all important. Hermes is involved.

The first and third cases are my own and the second is Mrs. Laporte-Steuerman’s.
as a refusal to accept this projection, and he feels that his projects are thrown back at him" (Grotstein, 1981).

The second case is a boy named Alexander who was a patient of Monica Laporte-Steuerman's. She had been treating him once weekly for four months. He was 10 years of age, a twin, and he and his twin brother are the oldest siblings in a large family. The twins were confined to their darkened room for most of their life until age four, when they were fostered for the first time. They were fed there, the dog was kept in there and was allowed to defaecate there. They were fed mostly scraps of food, and later used to cry whenever they saw other people's food. When they were fostered for the third time at age six, they seemed to have little idea of space or time, and did not even know how to make their own way down a street. The mother was neglectful and psychopathetic and sometimes violent but was not seriously abusive physically toward them, and was sometimes affectionate, but usually to the other, stronger twin. Alexander was extremely thin, like a reed, and seemed all mouth with protruding teeth. He had rubbery octopus's hands. He was a very adhesive child, who giggled a lot in a silly manner and made strange primitive sounds much of the time. His insidious quality did not however seem sinister or evil to Mrs. Laporte-Steuerman. His foster mother, who had helped to socialize the twins and to make them educable, was aware both of Alexander's insidiousness and also of his intelligence.

Mrs. S. began to feel that this boy was beginning to irritate her terribly. She knew he had been deprived; she knew he was all over the place and clumsy -- how could he be otherwise? He was ugly with strange teeth and a silly false placating grin -- how could he be otherwise? But yet she began to mind all this very much. She minded his awkwardness and clumsiness far more than she would have minded these qualities in other chaotic and deprived children. She had previously tried to be containing, understanding, receptive, but in the first session presented here we shall hear how she changes tack. I think we shall see that the new tack is much more than simply a question of setting limits. Setting limits is a helpful concept for dealing with management problems, but is inadequate as a description for situations where the management problem is not of the patient's wild behaviour, but of the therapist's strong reaction to the patient's often quite tame behaviour.

Here is the session.

"Alexander came in with a sort of 'net brief case' containing six balls. He throws balls under the sofa making quite a lot of noise (as the balls are heavy). He moves a lot, all over the place. He stops the play with the balls and goes to the big heavy desk. He starts pushing it very slowly. The friction of the desk legs against the ceramic tiled floor makes a very piercing noise. A. laughs at it and each time it happens he giggles, looking at me to see the effect. He wants to move it into a corner between the cupboards and the sink which is almost the size of a bath. This corner is exactly the same size as the desk.

A. pushes the desk into the corner but it gets stuck by the cupboards' handles. A. pulls and pushes impatiently and noisily. I am not sure if he is being clumsy or careless. He giggles a lot when he looks at me. Finally, dodging the desk, he manages to overcome one of the obstacles (there are three handles). While this has been happening I am silent, feeling quite disturbed and irritated. I can see the water stains at the back of the desk. Has he made them through his countless 'washings'? Is he going to scratch the desk with the handles?

I am trying to sort my feelings out, trying to think of what is happening between us when he goes to the taps and turns them on, letting a strong flow of water fall. It falls while he goes back to the desk, struggling to push it further into the corner.

After some water play he goes to the cupboard, getting some pencils, a ruler, scissors and Sellotape. He steps on the easy chair and stands on the low table beside me. He sticks pieces of Sellotape on the venetian blind rail.

A pencil falls on the table right beside me, making a rattling noise that at this moment I feel to be quite disturbing. I look up and see A., pencils under his left arm, making a slight, disguised movement, letting another pencil fall and finally all of them. He giggles.

I say, 'You're doing this on purpose.' He says, 'No I'm not.' I reply, 'You know very well you are.' I continue, saying that he comes into my room to move things around, spoil them, waste and drop them, making me feel spoilt, wasted and dropped.

He gets embarrassed and serious. I feel he became real.

I say he is embarrassed because he felt that I got to see a side of him and I am not going to let him get away with it.

He starts moving the little table beside me. He moves it slowly and clumsily, making faces and giving me the impression he knows he is getting under my skin. Many times he lets the table fall on the floor which makes a big 'bang' and he restrains a giggle when looking at me to see the effect of the noise.

I say to him that he thinks I am stupid as I don't hit him or do awful things to him. So he uses this and enjoys seeing me get upset and on edge that he might break something in my room (I was afraid he might let the table fall against the window glass, breaking it).

'You think people who are nice to you are also stupid,' 'Some are'.

It is time. We start tidying up. He pulls down the Sellotape, with the risk of making the rail fall. I show this to him. He does it properly.

I show him that he knows how to do it properly but that he has to try me and see if I'll let him get away with it. I also say that I have got in touch with a side of him that is clever and I am not going to let him forget about it. He leaves the room, returning to ask me if he should go to the waiting room.

I see him out.'

I want to make two points about this material. The first is that if we decide to assume that Mrs. S. is right and that there was a subtly provocative
element in this boy’s clumsiness, this would in no way account for the original cause of his clumsiness, or even all of his clumsiness now, but it would account for a way in which he now uses his clumsiness. I think this is something that occurs with many patients who have been ill since infancy. As they improve, some of the earlier defensive motives for the original madness recede and the symptom is used for much milder motives. It’s often hard to see the mischievousness of a relatively normal child in a particularly ghastly symptom.

I should also point out that there is no doubt that there was a certain hard edge to Mrs. S.’s voice when she described this session that is not normally there. I think this is probably almost a universal phenomenon: the first time we become conscious of a piece of counter-transference of which we have been previously unaware, our initial response is often quite strong. It’s important, I think, to note that she must, however, have done a considerable amount of transforming work within herself, because she did not really act out in the counter-transference. She didn’t shout, or end the session, or get into a scuffle. A common experience, I think, when the provocation has been subtle, is to find oneself acting out with sudden bursts of unreasonable, forcible restraint, or acting out verbally with an interpretation about the child’s fear of loss, say, which somehow carries a veiled threat. I think we should not guiltily set aside this type of acting out as simply an aberration, but rather as the first sign that something very important in the counter-transference may have been neglected by us. Only when it is finally confronted and examined, can it be transformed. There is a very fine line between acting-out in the counter-transference, and making the interpretation in such a way that the patient hears and feels its meaning. But it is a line that I believe can be drawn, and should be drawn. Fluctuations close to and sometimes over the line are probably inevitable. In fact, Mrs. S. learned later that fostering had nearly broken down precisely because Alexander’s foster mother had begun to find his subtle teasing unbearable.

At this early stage, however, it was not yet possible to understand Alexander’s wider motives for the provocation. Was he identified with the stupid ugly near-animal that his own mother may have felt he was? Did he feel provocation had become his only way of attracting her attention? He and Mrs. S. did not know yet. Remember that he did give Mrs. S. an embarrassed, serious, real look. I think sometimes for the child the experience of being known is so precious that the wags really can wait until later. They should never be a substitute for the wags. Getting those across is our first task. One can never be sure of anything in this work, but I think Hermes was with them that day.

Here is part of a session three weeks later.

“A. was carrying a black umbrella, closed.
As soon as we get into the room he praises my shoes and asks me, what do I think about his umbrella. ‘Do you like it?’ ‘It is nice, isn’t it?’
I tell him that it seems that we should begin today’s session praising one another, making sure one finds the other nice.
It is an automatic umbrella that when closed can have its size reduced.
He opens it and closes it, makes it big and small. He does this many times, asking me if I think it is nice and saying my shoes are nice.
I try to inquire what does he see in my shoes to feel they are so nice. He is unable to tell me. I say to him that I believe he wants us praising one another to do away with the fear he has of me.
In a frightened way he denies it. I tell him that he is frightened now, the moment I talk about his fear. He denies it again, going to the desk and starting to move it. He leaves the umbrella on the easy chair and now gets the low table beside me and giggles starting moving it around. He puts it lengthwise up, holding the top legs with his hands and the bottom legs with his feet. The table legs are T-shaped and A. starts playing a dangerous play which he calls ‘dodgy’.
I get on edge for fear that he might fall and say he knows very well he’s not supposed to play that way.
He jumps, slides and almost falls backwards with the table on top of him. I jump from my chair in a worried state to help him but he manages to balance and nothing happens.
He looks at my face and giggles, saying, ‘See, nothing’s happened.’ I say, ‘This is not true, something has happened, you’ve managed to see me jump and get worried about you.’
He wants to play ‘dodgy’ again. I stop him and he conforms.
He gets chairs and starts sliding around. He stops and starts moving the desk into a corner between the cupboards and the sink.
I say that this moving the furniture around makes me feel like he is moving parts of my body around, like moving my eyes to my ears, my mouth to my forehead. He’d like to change me all round.
He agrees, saying ‘Yeah! I would like to change you into the Incredible Hulk’.
I say to him that I think he is so frightened I may suddenly change into the Incredible Hulk that he prefers to feel he changes me before.
I try to understand what is the Incredible Hulk for him. He says it’s a green man that smashes everything up. I say he would like to turn me into this green Hulk man smashing everything up (he is still moving the furniture around).
He says, ‘I am not the Hulk, you are. You are in green trousers’. I say perhaps he thinks what I really am is the green Hulk disguised into a lady psychotherapist.
He agrees with satisfaction.
I say, ‘So you’re frightened that at any moment I may show you this Hulk me’.
He, in a frightened way, ‘No!’ I say that he gets frightened even when I only speak about it. ‘You’re frightened now’, I say.”
Two things are interesting about this ensuing session: first, Mrs. S. no longer feels annoyed by Alexander’s furniture-moving; second, they have begun to explore together some of the motivations and anxieties behind his behaviour. This of course accords much more with the ideal of the psychotherapist’s function. Yet the question remains: could this fruitful second session have occurred with this particular child without the irritations of the first? Could the second stage have been achieved in any real way without at least some of the counter-transference elements which obtained in the first? If the analytic process is like other living processes, then it too may have its expansions and contractions, its wave formations and rhythms.

The third case is a boy patient of mine named Cyrus. He is eight years old and was referred at age five for various phobic fears and separation difficulties. His family had come from abroad when he was aged two years from a country which has had major political upheavals for some years now. They belong to a small, somewhat threatened, religious minority within that country. The parents and an older sister of 15 continue to suffer much depression, anxiety and concern for friends and relatives at home.

I have chosen his material because I think it illustrates, in a way similar to Mrs. S’s, Alexander, some problems for the therapist in the communication of understanding. My patient is a child I feel I’ve come to know well. He comes five times a week and he has been coming for three years. Analyzing his destructiveness and apparent destructiveness is difficult because he seems to be a very tricky patient. He is no longer phobic – that part was fairly easy; he seems well able to enjoy his life, can separate from his parents fairly well and has many friends. He is still very much an under-achiever at school. A major problem has been a continuing repetitive destructive play, and a total refusal to let me speak, which at times seems based on genuine rage: he is a terribly possessive controlling child and reacts passionately and exorbitantly to things like breaks. Sometimes he has feigned rage and felt nothing. At other times, he has feigned rage but felt real fury underneath. He is an actor and also a juggler with his own emotions.

A further problem has arisen, however. It is partly a problem in my understanding, but, even more, a problem in the communication of whatever understanding I am able to achieve. The problem is this: I began to feel that this child’s destructiveness — constantly destroying play materials, constantly beginning to shout, sing or swear the moment I began to speak — had become quite motiveless. That seems a defeatist, unthinking thing for a psychotherapist to say, since we are supposed to be in the business of trying to understand motives. What I mean by it is that he had become stuck and addicted to a mode of being with me that had begun from defensive motivations and acquired destructive controlling motivations along the way, but had somehow gradually lost its heat. The heat, however, was not completely gone. His behaviour was, for example, still fed by his narcissism. That was clear, and yet the interpretation of this didn’t change much. There are patients who do exploit and misuse and do not seem to benefit from the non-retributive, tolerant qualities of child psychotherapy. I set limits on physical damage to me or the room but nothing seemed to limit his other more subtle but powerful forms of destructiveness. The timing of his interruptions whenever I began to speak was impeccable and wonderfully effective. There were times when this was clearly defensive — he is a passionate, easily hurt child. There were also times when it was very sadistic. But the more difficult problem concerned the timing when even real sadism was absent. He took, by the end of the third year, relatively little relish in disappointing me over and over again, but he just couldn’t or wouldn’t stop. The layman might say that he had some very bad habits, and there certainly was something casual and habitual about it.

I began to feel that the longer I went on containing this, the longer it would last. I started to have fantasies like “All this child really needs is a good spank!” I had certainly begun to feel a weariness and boredom with the repetitive quality, after many years of interpreting the intense motives, but, like Mrs. S., I didn’t feel certain that I should feel bored. I alternated between searching for as yet undiscovered motives for the immobility, when I’m certain I sounded somewhat hypocritical, and beginning to make interpretations like “You take for granted I’ll go on forever”, etc. which did at times carry the kind of veiled threat I spoke of earlier. As I have pointed out, there’s a fine line there. If some proper work has been done on oneself, the same interpretation can be made without too much emotion, yet not altogether empty of emotion either. At this stage of uncertainty and unawareness I think I sometimes let it pop out vengefully.

In January of this year, I noticed that although I often gave up speaking when Cyrus interrupted me with his “Blah-blahs” or his obscene curses, I had never ceased to watch his dramatic antics. He often enacted very vividly some drama, usually a battle between two powerful heroes. He is a lively, appealing child, and in many ways, a pleasure to watch. He was also, as I’ve said, narcissistic. On January 14th, I began to watch him less. I found, for example, that I could just as easily interpret while looking at the floor. By January 17th, he had become much more alert; by the 18th, he actually listened to one or two interpretations, and by the 20th, he was actually pausing in his play to hear me out. I am not suggesting there is any magic in itself in the question of where one puts one’s gaze; although in Richard’s case, e.g. I believe it was very important to look. But with Cyrus I think the change of direction of my gaze was accompanied by many other changes. For example, there was a change in the length of my interpretations — they got shorter — and in my tone of voice — I think I allowed it to sound a little weary, a tiny bit bored. Maybe there was also a little chill in it. I did not design and could not design, and am not recommending designing such changes. I believe they followed from the examination of my counter-transference impressions that the child no longer needed, nor even particularly wanted to behave the way he did.

I have mentioned the tiny little hopeful signs. In between, however, things
continued pretty much as usual, with obscene swearing, wild, excited, hugely noisy, exhibitionistic play.

On Monday 24th January I had to cancel a session because I was ill.

On Tuesday I felt that although his behaviour was unchanged, his eyes were on me much of the time.

On Wednesday the exciting battle of the giants went on as usual and his attacks on my voice were particularly cruel. I spoke firmly about his cruelty and he then played that he was shooting his enemy's tyres. Suddenly he said, "They're flat", and looked very worried. I said he was afraid that I was exhausted and drained, and that that was why I'd gotten ill. I also said he was afraid I would run out of energy and hope and give up with him altogether. He gave me a very direct vulnerable look, and then ralled cockily and pointed his two fingers at me, pointing to the area between my breasts, pretending that his fingers were a gun, and said, "I've got a good aim!" I agreed. I said he had perfect aim, that he knew exactly where to produce depression in me. I should have said "he feels he knows", but even then there would have been no doubt that I was saying it from the heart. It seemed to hit him; he gave me a very clear-eyed look.

The next session, Thursday, was quite moving. I felt that almost for the first time, this very manipulative, charming, dishonest little boy spoke to me in a straightforward manner. At the beginning of the session, he said bitterly, "You never listen, you just look round the room". (I think that was high praise.) Later he said "This place is like a prison". He was protesting passionately, and yet the usual shrill melodramatic quality was absent. I interpreted that he felt the prison was himself and that he felt lately I wouldn't let him escape. Then he said, "I feel sick". I said, gently, since I felt very sorry for him at that moment, "Perhaps you feel sick of yourself". He said, unconvincingly, "No - you". Then he added, "Well, mostly you". He was near to tears. I said, "A bit you, though". To my surprise, he agreed.

The next session was Friday. He came a couple of minutes early and waited quietly. Downstairs he said, "See, I'm empty-handed". He often brings his own toys, which I have interpreted as his fear of coming empty-handed. Then he said, brightly and falsely, "I'm looking so forward to Saturday". I said, "Well, you're not empty-minded". He then insisted that at least he was empty-handed, and I acknowledged that he had made a considerable effort to manage that.

Then he decided to build what he called a "torture place". He was being shot at, but he was only an actor, it wasn't real shooting. He seemed to be trying to dilute the feelings of persecution, and the fascination with masochistic violence, but it was quite a struggle. I said that he felt it was very cruel to have to come here empty-handed, especially on a Friday and it was terribly cruel of me to be so full of stuff I was trying to give him. Here I was interpreting the feelings of persecution and defensiveness that I think were there, but as I did so, it began to change. This child readily despises and exploits containment. He got noisier and noisier and his voice became more and more horribly intrusive, so I began to speak about his cruelty. He refused to let me speak. I then said with much conviction that I did not believe he did think I was cruel. He seemed to hear me but went on playing. He played Evel Knievil, the stunt man with the bullet proof vest, dodging the bullets. I said he felt I was the one who needed a bullet proof vest. He looked worried, but got louder.

Then he changed to playing Luke Skywalker, the hero of Star Wars. Then he sort of collapsed on the couch, nearly fell off and looked close to tears. He made an effort to produce a riddle, a guessing game. Most of his conversation in the past consisted of this type of beginning "Can you guess what?" or "Do you know what...?" But this time his heart wasn't in it. What he said instead was, "What's the difference between... garbage and Cyrus? No - Star Wars and Cyrus?" I tried to speak about the first, and he tried to push me on to the second. I stuck to the first, and said that I thought he was afraid that if he stopped his cruelty and noisy games, he'd be too empty-handed. There'd be just garbage in him. He said with passion, "There is!" I said, "You feel there isn't!" He was close to tears and shouting. He is a child who can be very persecuted by guilt, and I felt sorry for him, but I think I reassured him too quickly. Such rare moments of honesty about what a con-man he is do need delicate handling, but could perhaps have been allowed to last a little longer.

Then he moved half off the couch, looking at me from an upside down position, and said, "My name is Cyrus Joseph Khaled". Then he told me his father had many more names than that. Then he mused, "That's the first time I've ever told anyone my middle name". I said, "Perhaps that's a part you don't know, not garbagy, but not a stunt man either". I searched for a word, and he said, very seriously, "Clean?" Then he altered that to "Near". I was still searching. I said, "Yes, but I think it's more than that - it's something valuable - something which shouldn't be thrown away". He said, "out of the blue, and quite matter-of-factly, "Rachel's the only one I show that part to" (his sister). There was more about this, and then he got talking about whether or not he could make himself dream the dreams at night he wanted to. Gradually the old stage pro returned, he got smoother and smoother and he began to confabulate. I said, "You're spinning me a line". He agreed with a sheepish grin, and sank back down on the couch. He said, sighing, "I can't wait for Saturday". But he helped me clear up.

A paper by David Tuckett called Words and the Psychoanalytic Interaction discusses a review by Bullowa of the research on interactional synchrony. The researchers do frame by frame analysis of films of two people having a conversation. Bullowa argues that the research shows that language is inseparable from bodily, mental and social matrices. Tuckett concludes that listening involves a process of physical and bodily response to the speaker which is involuntary and presumably unconscious (1983). I have tried to suggest in this paper that while receptive containment in the counter-
transference is a fundamental aspect of our work, transformation and the effective communication of the interpretation are equally fundamental to the therapist's activity. I would add that I think Bion's notion of alpha function, the mental process which allows thoughts to be thought about, and which endows experience with meaning, is highly relevant to this problem (1962). If the therapist's aim is to help the patient to think with feeling, then he must make interpretations which can be experienced and heard by the patient as meaningful. These are more likely to arise when the therapist is honest with himself about his counter-transference, than when he denies it.

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