deprives it of meaning for its experiences (this is referred to as 'minus-K' (or '−K'); and (iii) a state of absence of 'K' ('no K') in which the capacity to know has been destroyed, giving rise to a paranoid psychotic condition in which the ego has been severely weakened by splitting and projection of its capacity for K and faces hostile objects into which, in phantasy, bits of the ego have been violently expelled [see EPISTEMOPHILIA].

Bion's theory of thinking is, in the main, adopted by Kleinians as a whole. There is a variation in the extent to which it is used (even understood) and some people have researched it further in their own right. The most ambitious of these is Meltzer (1987).

Bion, Wilfred (1959) 'Attacks on linking', *Int. J. Psycho-Anal.* 40:308–15; republished (1967) in W.R. Bion, *Second Thoughts*. Heinemann, pp. 93–109.
—— (1962a) 'A theory of thinking', *Int. J. Psycho-Anal.* 43:306–10; republished (1967) in *Second Thoughts*, pp. 110–19.
—— (1962b) *Learning from Experience*. Heinemann.
—— (1963) *Elements of Psycho-Analysis*. Heinemann.
—— (1970) *Attention and Interpretation*. Tavistock.
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—— (1931) 'A contribution to the theory of intellectual development'. *WMK* 1, pp. 236–47.
Meltzer, Donald (1987) *Studies in Extended Metapsychology*. Perth: Clunie.
O'Shaughnessy, Edna (1981) 'A commemorative essay on W. R. Bion's theory of thinking', *Journal of Child Psychotherapy* 7:181–92.
Spillius, Elizabeth Bott (1988) *Melanie Klein Today, Volume 1: Mainly Theory*. Routledge.

Transference

Transference was known from the very beginning of psychoanalysis. The way it is understood and its impact on theoretical development have constantly changed. The concept of transference is really several concepts that have unfolded over the course of more than a century: (1) it was an unethical, untoward event; (2) it was then the psychoanalyst's ally in overcoming resistances, when hypnotic methods showed themselves to be limited and only transiently beneficial; (3) it could present a form of resistance to analysis by making the working relationship into an emotional one; (4) then it came to be seen as the re-enactment of the past, giving a new clarity to the psychoanalytic reconstruction of the details of childhood traumas; (5) alternatively, the enactment in the consulting room could be seen as the externalization of current unconscious phantasy; and (6) finally, a multiply split set of relationships with the analyst were described.

(1) **An untoward event.** When Breuer first reported to Freud what was termed by them 'an untoward event' (Jones, 1953), it was in fact the realization that Anna O. had fallen in love with Breuer. Breuer then decided straight away that his method was unethical for a medical practitioner, and he left the field for Freud to struggle on alone. Freud was more circumspect. He looked around the edges of the ethical problem and, being a well-brought-up natural scientist, he adopted the characteristic neutrality to ethical questions. He decided to look at Anna O.'s love as a phenomenon for study. This meant abstaining from any personal satisfaction in the relationship. The love was to be held as a phenomenon which was entirely remote from the actual person of the analyst, and when he found the anxious affections of his other young lady patients turning towards him in the same way, he refused to accept that it was due to his own personal charms.

Thus, transference was looked at anew – from being an untoward and unethical happening it could become a phenomenon for study, and then for use in practice.

(2) **Overcoming resistances.** At the time when Freud began to relinquish the hypnotic method for gaining access to the patient's unconscious, he had ready to hand the transference as an alternative means for overcoming the resistances to psychoanalytic exploration. Transference at that stage (in the 1890s) was simply the positive affection of the patient for the analyst which the analyst used as if it were a charge of energy [see LIBIDO] to set against the resistance to recalling memories from the past. He simply played on the positive and fantastical loyalty of the patient to press him or her to relax the repressive forces – the 'pressure technique'.

(3) **Transference resistance.** Transference was abruptly brought to Freud's attention again by the Dora case. In a general sense, Freud had already realized that the patient could harbour unnaturally hostile feelings towards the analyst, as well as unnaturally positive feelings. However, he delayed acknowledging their importance until Dora broke off her analysis very prematurely and with a good deal of unkindness. Freud was especially hurt as he had started the Dora analysis in order to write up an exemplary case that would be a model for all future practice. She made him swallow his pride and recognize that this had been a model of how not to practise – at least a model of how not to deal with transference. His overcoming of his disappointment was only part of the adjustment he had to make.

The importance of the negative transference meant a revision of both his practice of psychoanalysis and of his theories. Freud tended to take two views of this occurrence in the case of Dora. First, he regarded the transference, in which the whole analysis was broken off,

as a form of resistance against the work of analysis and the recovery of memories and phantasies from the past (Freud, 1912). By engaging in an intensity of feeling towards the analyst the patient was attempting, through seduction or hostility, to thwart the process of understanding the past. Then secondly, Freud also thought of the relationship between Dora and himself as an enactment of a *specific* relationship of some kind (Freud, 1915).

(4) **Repetition in the transference.** Freud could see how Dora's negative transference recapitulated certain feelings she had previously felt towards a certain Herr K. He had in fact known that transference was linked to the early traumas in the patient's history. Now he had a real lesson in how the trauma is relived, re-experienced, re-enacted, as real life – in the transference to the analyst. And Freud was able to write up his case – not as an exemplary one but as a cautionary tale that demonstrated in a new way the importance of transference: the very detailed way in which the past could be witnessed. It was no longer a case of retrieving hazy memories confused by the efforts to keep them repressed.

In spite of this painful lesson in transference, Freud remained, as always, reluctant to give up completely his earlier views. Even today descriptions of transference imply that it is both a force for or against the resistance to analysis and a dangerous re-enactment of the past.

(5) **Enacting unconscious phantasy.** Over the years since then, the transference as a *re-enactment* has been further developed. A new meaning has supervened on the idea of a re-enactment of the past. This further development has resulted from the work of Klein. Perhaps one of the important factors in her revision of transference was the fact that she was working with children, some as young as two, and therefore at a time when the traumatizing events were assumed to be taking place. Thus the re-enactments of children were not from the far-gone past, but from their immediate present. The whole of their play was a series of enactments of all kinds of happenings and relationships. The vivacity and vigour of the re-enactment were astonishing to her. What, then, were the children enacting in their play? Clearly children enact their phantasy life. Klein took this seriously. Play, she thought, was in earnest; it was not just for amusement. It was the child's own way of relating to himself his own worst fears and anxieties. The relationships enacted in the consulting room were, then, the expressions of the child's efforts to encompass the traumatic way he experiences his daily life.

Reverting to the practice of adult psychoanalysis, this new realization had a profound effect on both theory and practice. Transference, already regarded as an enactment in the consulting room, was now

regarded as a re-enactment of current phantasy experiences in the way the child's play is a re-enactment of his phantasy elaboration of his traumas [see ACTING-IN]. This view of transference, as coming out of the here-and-now difficulties actually during the session of the analysis, was bolstered by the development of, and emphasis upon, the notion of unconscious phantasy [see 2. UNCONSCIOUS PHANTASY]. The practice of Kleinian psychoanalysis has become an understanding of the transference as an expression of unconscious phantasy, active right here and now in the moment of the analysis. The transference is, however, moulded upon the infantile mechanisms with which the patient managed his experiences long ago:

> . . . the patient is bound to deal with his conflicts and anxieties re-experienced towards the analyst by the same methods he used in the past. That is to say, he turns away from the analyst as he attempted to turn away from his primal objects. (Klein, 1952, p. 55)

This view of transference came, in turn, to bolster the concept of unconscious phantasy. These two concepts have developed reciprocally as the core of Kleinian practice.

Acting-out in the transference: More recently there has been increasing interest in the way the patient acts out in the transference. This development, particularly connected with the work of Betty Joseph [see PSYCHIC EQUILIBRIUM], has demonstrated that patients use the transference not just for the gaining of satisfaction of their impulses but also for the support of their defensive positions [see ACTING-IN]. The patient attempts to 'use us – analysts – to help them with anxiety' (Joseph, 1978, p. 223). She describes extremely subtle ways in which the patient attempts 'to draw us into their defensive systems' (Joseph, 1985). By emphasizing the transference as the total situation (Joseph, 1985) she has investigated difficult and intractable borderline patients whose personalities are constructed around a rigid system of defences, a pathological organization [see PATHOLOGICAL ORGANIZATIONS].

Ego-psychology techniques: One of the differences in the approach to transference is that ego-psychologists will look at the material for the evidence of impulses, instinct derivatives and the defences against these, while others will look for objects and the relationships to them.

However, there is a deeper layer to this difference. What Klein started was a different emphasis in looking at the material the patients produced. She was concerned with the *content* of anxieties, and in this she was stepping aside from the prior interest in the instincts and the discharge of their energy. Analysts are either interested in approaching the structure of the patient's mind in objective terms, building a model of that structure and working to modify it, or, on the other hand,

analysts enter the subjective world of the patient and attempt to find words to grasp it. These approaches to psychoanalytic practice, which brought their protagonists into such conflict in the 1920s over the technique of child analysis, remain in clear contrast today in the analysis of adults [see 1. TECHNIQUE; CHILD ANALYSIS].

(6) **Split transferences.** From the 1940s onwards, Klein introduced a further development in the understanding and therapeutic interpretation of transference. Abraham (1919) and subsequently many other analysts pointed to hidden aspects of the patient's relationship to the analyst: usually it is negative aspects that are concealed. Klein could embrace this with her developing theory in the 1940s when she began to understand the importance of splitting. She could show that all material given in the course of free association in an analytic session may show aspects of the immediate transference to the analyst now, even when the material does not refer explicitly to the analyst or even when it apparently consists of childhood memories:

> For instance reports of patients about their daily life, relations, and activities not only give an insight into the functioning of the ego, but also reveal – if we explore the unconscious content – the defences against the anxieties stirred up in the transference situation . . . he tries to split the relations to him [the analyst], keeping him either as a good or as a bad figure: he deflects some of the feelings and attitudes experienced towards the analyst on to other people in his current life, and this is part of 'acting out'. (Klein, 1952, p. 56) [see 1. TECHNIQUE]

The sequence of associations in the material is really an account of the (unconsciously) splintered set of remnants of the relationship with the analyst, often very immature aspects of that relationship. The task of the analyst is to understand how he is represented in this myriad of conflicting ways, and that they must be brought back together in a 'gathering of the transference' (Meltzer, 1968).

Countertransference: In the course of this historical journey of the concept of 'transference', a somewhat similar journey was traversed by the concept 'countertransference'. This too started as an interference and something off-putting of which the analyst was very wary. Psychoanalysts sheltered behind the idea that they could present a blank screen to their patients because they may actually have been frightened of how much they were stirred by their patients (Fenichel, 1941). However, from about 1950 onwards the idea of the analyst as a blank and mechanical operator fairly quickly fell into disrepute, for two reasons: (a) an analyst cannot, in practice, keep his own personality secret; (b) the feelings that an analyst discovers in himself in the course

of his sessions have, if carefully processed, considerable importance in understanding the state of mind of the patient he has with him at the moment [see COUNTERTRANSFERENCE].

Abraham, Karl (1919) 'A particular form of neurotic resistance against the psycho-analytic method', in Karl Abraham (1927) *Selected Papers on Psycho-Analysis*. Hogarth, pp. 303–11.
Fenichel, Otto (1941) *Problems in Psycho-Analytic Practice*. New York: The Psycho-Analytic Quarterly Inc.
Freud, Sigmund (1912) 'The dynamics of transference'. *S.E.* 12, pp. 97–108.
—— (1915) 'Remembering, repeating and working through'. *S.E.* 14, pp. 121–45.
Jones, Ernest (1953) *The Life and Work of Sigmund Freud*, vol. 1. Hogarth.
Joseph, Betty (1978) 'Different types of anxiety and their handling in the analytic situation', *Int. J. Psycho-Anal.* 59:223–8.
—— (1985) 'Transference – the total situation', *Int. J. Psycho-Anal.* 66:447–54
Klein, Melanie (1952) 'The origins of transference'. *WMK* 3, pp. 48–56.
Meltzer, Donald (1968) *The Psycho-Analytic Process*. Perth: Clunie.

The unconscious

The notion of the unconscious is one of the few concepts that have remained relatively unchanged in the course of the development of all the schools of psychoanalysis. The unconscious system is conceived of as primitively active from the beginning – as unknown, but nevertheless a dominating influence on the life of the person. It is a fact in psychoanalysis that most of mental life is not accessible to the conscious mind (Freud, 1915).

Freud explored the symbolic aspects of the unconscious and came up with certain rules of unconscious mental activity – displacement and condensation. These terms describe the way in which symbols are handled in the unconscious. Klein and her followers respected these concepts by adding to and elaborating them. In particular, Kleinians have developed the notion of unconscious phantasy [see 2. UNCONSCIOUS PHANTASY].

The unconscious is structured like a small society. That is to say, it is a mesh of relationships between objects. An unconscious phantasy is a state of activity of one or more of these 'internal' object-relations. Isaacs says that instincts, when active physiologically, are mentally represented as relationships with objects. Thus a somatic sensation tugs along with it a mental experience of a relationship with an object that causes the sensation, is believed to be motivated to cause that sensation and is loved or hated by the ego according to whether the sensation is pleasant or unpleasant. In this way a sensation that hurts becomes a mental representation of a relationship with a 'bad'

At this point the British Society was riven with dispute as Klein and her close associates reacted badly to the criticisms and entrenched themselves in attempts to force their theories and their clinical material upon the newcomers. Committee business in the Society, already hampered by the dislocations of the Second World War in 1940 and 1941, became impossible, especially over the training of new psychoanalysts. A truce was eventually arranged, with an agreement to a series of monthly scientific meetings to discuss the controversial aspects of Klein's theories. Over a period of eighteen months a series of four papers was read by Kleinians on controversial aspects of their theories: in 1943 'On the nature and function of phantasy' by Susan Isaacs, discussed over five meetings; 'Certain functions of projection and introjection in early infancy' by Paula Heimann, discussed at two meetings; and 'Regression' by Paula Heimann and Susan Isaacs, discussed at two meetings; and then in 1944 (though by this time most of the Viennese analysts had ceased to attend the meetings and Glover had resigned from the Society altogether) 'The emotional life of the infant with special reference to the depressive position' by Melanie Klein, discussed at two meetings. These papers were published in rewritten forms in *Developments in Psycho-Analysis* (1952).

The Controversial Discussions resolved no scientific issues. They did concentrate the minds of the Kleinians to produce systematic accounts of their views and also demonstrated, to the surprise of the Viennese, the British analysts' sophistication and power of argument. The outcome was for each side to leave the other alone and to agree to a bureaucratic solution for the committee structure of the British Society and for the training of new psychoanalysts. The final agreement has been known as 'the Gentlemen's Agreement', though it was entered into by three women: Melanie Klein, Anna Freud and the President of the British Society, Sylvia Payne (Grosskurth, 1986). Since then a carefully controlled parity of membership on committees, especially the training committees, has been maintained by designating three groups within the society – the Klein Group, the 'B' Group, now called Contemporary Freudians, and a Middle Group of Independents.

Glover's summaries of his criticisms of the Kleinian papers were subsequently published (Glover, 1945) and Brierley was stimulated to write a number of papers which were collected together as a book on the new form of psychoanalysis (Brierley, 1946). Direct confrontations between Kleinian psychoanalysts and orthodox psychoanalysts (or ego-psychologists, as they have become) have tended to be avoided ever since; the debate between Greenson (1974, 1975) and Rosenfeld (1974) and the conference in 1985 on projective identification (Sandler, 1988) are rare published exceptions.

See 2. UNCONSCIOUS PHANTASY; 4. OEDIPUS COMPLEX

Brierley, Marjorie (1946) *Trends in Psycho-Analysis*. Hogarth.
Glover, Edward (1945) 'An examination of the Klein system of child psychology', *Psychoanal. Study Child* 1:1–43.
Greenson, Ralph (1974) 'Transference: Freud or Klein?', *Int. J. Psycho-Anal.* 55:37–48.
—— (1975) 'Transference: Freud or Klein? A reply to the discussion by Herbert Rosenfeld', *Int. J. Psycho-Anal.* 56:243.
Grosskurth, Phyllis (1986) *Melanie Klein*. Hodder & Stoughton.
Jones, Ernest (1936) 'Early female sexuality', *Int. J. Psycho-Anal.* 16:262–73.
Riviere, Joan (1936) 'On the genesis of psychical conflict in earliest infancy', *Int. J. Psycho-Anal.* 17:395–422; republished (1952) in Klein *et al.*, eds *Developments in Psycho-Analysis*. Hogarth.
Rosenfeld, Herbert (1974) 'Discussion of the paper by Ralph R. Greenson, "Transference: Freud or Klein?"', *Int. J. Psycho-Anal.* 55:49–51.
Sandler, Joseph, ed. (1988) *Projection, Identification and Projective Identification*. Karnac.
Steiner, Riccardo (1985) 'Some thoughts about tradition and change arising from an examination of the British Psycho-Analytical Society's Controversial Discussions 1943–1944', *Int. Rev. Psycho-Anal.* 12:27–71.
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Countertransference

Countertransference underwent a remarkable metamorphosis in the 1950s to become an elegant concept central to modern psychoanalytic techniques. Heimann emphasized the human side of the patient/analyst transaction:

> The aim of the analyst's own analysis is not to turn him into a mechanical brain which can produce interpretations on the basis of a purely intellectual procedure, but to enable him to *sustain* his feelings as opposed to discharging them like the patient. (Heimann, 1960, pp. 9–10)

Her main thesis was that by '. . . comparing the feelings roused in himself with the content of the patient's associations and the qualities of his mood and behaviour, the analyst has the means for checking whether he has understood or failed to understand his patient' (p. 10). Previously Ferenczi (1919) had already described the offputting quality of the analyst who defends himself against any countertransference, and Fenichel (1941) also criticized the 'blank screen' view of the analyst's role. At this time, as well as Heimann and Racker in the Kleinian tradition, there was a widespread movement to take countertransference seriously (Winnicott, 1947; Berman, 1949; Little, 1951; Gitelson, 1952; Annie Reich, 1952; Weigert, 1952).

There are various steps in the history of the Kleinian concept of 'countertransference': (1) The importance of the analyst's feelings as

an indicator of the patient's state of mind; (2) the discovery of a normal form of projective identification which is used as a method of *non-symbolic* communication; (3) cycles of introjective and projective identifications as the basis of an intrapsychic understanding of the interpersonal transference/countertransference situation between analyst and patient; (4) the idea of 'normal' countertransference; and (5) the importance of the analyst's mind above all else as the significant aspect of the patient's environment [see 1. TECHNIQUE].

(1) **Countertransference as indicator.** Heimann (1950, 1960) drew attention to the aspect of countertransference that is a *specific* response to the patient, and distinguished it from the intrusion of the analyst's own neurosis and neurotic transference into the psychoanalytic work. The countertransference, because of its potential specificity for the individual patient, may therefore become a precise instrument for probing the patient. This significant idea, though rejected by Klein herself, was specifically acknowledged by Rosenfeld (1952, p. 72) and by Bion (1955, p. 225).

(2) **Normal projective identification.** Subsequently Money-Kyrle (1956) and later Bion (1959) formulated clearer pictures of the analyst as a container for the patient's intolerable experiences, which, through the analytic process of putting experience into words, are thereby *contained*. This arose from distinguishing normal projective identification from the pathological form [see 13. PROJECTIVE IDENTIFICATION] and allowed a theory of the nature of empathy and also of the therapeutic effect of psychoanalytic interpretations to follow. Following the discovery of the phantasies involved in the mechanism of projective identification, it became possible to formulate, in *intrapsychic terms*, the *interpersonal* situation of the analytic setting. The analyst actually has his or her own feelings, just as the patient does (Heimann, 1950). Although Klein never really adopted this way of looking at the analytic session (though her observations of mothers and babies [Klein, 1952] are definitely pointing to the interpersonal interaction at the unconscious level), this 'un-Kleinian' interest in countertransference has become central to Kleinian practice today. And although Heimann never accepted projective identification as a significant concept and eventually broke away from Klein [see HEIMANN; KLEINIAN GROUP] she nevertheless strongly influenced the younger generation of Kleinians, who did relate countertransference to projective identification.

(3) **The analyst as a maternal container.** Bion (1959, 1962) developed these views into a more rigorous theory of maternal and therapeutic containing and used the concept of projective identification to illuminate the interpersonal interaction [see CONTAINING]. In this

view the infant cries, and performs a form of projective communication in which his distress is actually felt (introjected) by mother. If she is a capable mother and in reasonably good form at the moment she can do mental work inside herself to define the problem and what is needed to deal with it. This is an important ego-function involved in mothering [see REVERIE]. Being able to discern something of what is amiss, she can take action to provide for the child in such a way as to relieve something of the distress. The process of defining the distress and dealing with it is communicated in the act of dealing with the infant – say feeding him. This is a form of projecting back (reprojecting) the distress in the form of an understanding action. The child, once the mother has begun to provide and minister to his distress, can then take back his experience of distress – reintroject it – but now in a modified form. It has been modified by mother's function of defining and understanding the distress, expressed to the baby through the appropriate actions that help him. The experience thus bears the marks of mother's understanding imprinted in the modification of the experience. It is now an understood experience and, in the interaction between these two intrapsychic worlds, meaning has been generated. By introjecting this understood experience the infant can come to acquire the understanding that mother has – for example, if mother is accurate, he can realize through her ministrations that a certain experience means hunger (i.e. requires something to be put against his lips for sucking and feeding purposes). The accumulated occasions on which experiences have been understood begin to amount to an acquisition, inside himself, of an internal object that has the capacity to understand his experiences. This, as Segal puts it, '. . . is a beginning of mental stability' (Segal, 1975, p. 135). Segal described this mother–child interaction as a model for the therapeutic endeavour of the analyst [see CONTAINING].

(4) **Normal countertransference.** One of the problems in using countertransference in this way is the status of the analyst's feelings: whether they lead him to understand the patient or whether they result in his defensive evasion of his own feelings, with subsequent harm to the progress of the analysis. Money-Kyrle expressed this problem well when he distinguished 'normal countertransference'. When the process of analysis is going well:

> . . . there is a fairly rapid oscillation between introjection and projection. As the patient speaks, the analyst will, as it were, become introjectively identified with him, and having understood him inside, will reproject him and interpret. But what I think the analyst is most aware of is the projective phase – that is to say, the phase in which the patient is the representative of a former immature or ill part of himself, including his damaged objects, which he can now

> understand and therefore treat by interpretation, in the external world. (Money-Kyrle, 1956, pp. 331–2)

Money-Kyrle was describing that familiar experience of realizing that the interpretation one is making may well be made of oneself; and he also recognized the equally familiar possibility that '. . . by discovering new patterns in a patient, the analyst can make "post-graduate" progress in his own analysis' (p. 341).

The countertransference problem: However, this is '. . . normal only in the sense of being an ideal, . . . his [the analyst's] understanding fails whenever the patient corresponds too closely with some aspect of himself which he has not yet learned to understand' (p. 332). In this case the analyst fails, by reason of his own neurosis, to comprehend the patient. This becomes apparent to the analyst as the feeling '. . . that the material has become obscure'. This causes strain for the analyst, and is an event to which the patient also responds. The strain and anxiety tend, Money-Kyrle says, to diminish further the capacity to understand, and a vicious circle has set in. It is at these points that the traditional concept of countertransference comes in – the interference by the analyst's own personal difficulties in the course of his understanding of the patient's difficulties. The analyst:

> . . . may become conscious of a sense of failure as the expression of an unconscious persecutory or depressive guilt . . . when that interplay between introjection and projection breaks down, the analyst may tend to get stuck in one or other of these two positions; and what he does with his guilt may determine the position he gets stuck in. In accepting the guilt, he is likely to get stuck with an introjected patient. If he projects it, the patient remains an incomprehensible figure in the external world. (p. 334)

This framework provides an extremely clear view of what goes wrong with countertransference.

Little (1951), Gitelson (1952) and many others have speculated on a particular method of getting out of this entrapment with one's own unconscious: by confiding one's mistake to the patient. But this method is condemned by Heimann (1960) as burdening the patient with the analyst's own personal matters. Money-Kyrle also argued, with clinical illustration, that the confession may amount to a collusion with the patient's projections. If the analyst has failed to understand, the patient is in a position to project into the analyst an impotent part of himself, so a subsequent attitude of contrition and humility on the analyst's part is not necessarily taken by the patient in the way it is intended by the analyst. The patient may instead take the analyst's attitude as confirmation of the projected impotence. Money-Kyrle described a patient who responded to the analyst's loss of understanding by:

> . . . behaving as if he had taken from me what he felt he had lost, his father's clear, but aggressive, intellect, with which he attacked his impotent self in me. By this time, of course, it was useless to try to pick up the thread where I had first dropped it. A new situation had arisen which had affected us both. And before my patient's part in bringing it about could be interpreted, I had to do a silent piece of self-analysis involving the discrimination of two things which can be felt as very similar: my own sense of impotence at having lost the thread, and my patient's contempt for his impotent self, which he felt to be in me. Having made this interpretation to myself, I was eventually able to pass the second half of it on to my patient, and, by so doing, restored the normal analytic situation. (Money-Kyrle, 1956, pp. 336–7)

This process described by Money-Kyrle is clearly a cycle of projective identification into the analyst followed by the analyst's modification (silent piece of self-analysis), and the reprojection to the patient in the form of the analyst's interpretation, for possible reintrojection by the patient.

Drawing the analyst in: Money-Kyrle's view of countertransference developed the Kleinian idea of transference [see TRANSFERENCE]. With the idea of projective identification the analyst is more than just misperceived by the patient:

> We see the patient not only as perceiving the analyst in a distorted way, reacting to this distorted view, and communicating these reactions to the analyst, but as also doing things to the analyst's mind, projecting *into* the analyst in a way which affects the analyst. (Segal, 1977, p. 82) [see 13. PROJECTIVE IDENTIFICATION]

Joseph (1975) has considerably refined the analyst's sensitivity to the patient's enactments in the transference [see ACTING-IN]. She described the analyst's own experience as very important in sensing how the patient is 'drawing the analyst in':

> how our patients act on us for many varied reasons; how they try to draw us into their defensive systems; how they unconsciously act out with us in the transference, trying to get us to act out with them; how they convey aspects of their inner world built up from infancy – elaborated in childhood and adulthood, experiences often beyond the use of words, which we can only capture through the feelings aroused in us, through our counter-transference. (Joseph, 1985, p. 62)

This increased sensitivity has enabled analysts to make headway with difficult 'unreachable' borderline patients who seem stuck [see PSYCHIC EQUILIBRIUM: PATHOLOGICAL ORGANIZATIONS]

This view of countertransference is in line with the Kleinian idea of transference [see TRANSFERENCE]. With the idea of projective identification the analyst is more than just misperceived by the patient:

> We see the patient not only as perceiving the analyst in a distorted way, reacting to this distorted view, and communicating these reactions to the analyst, but also as doing things to the analyst's mind, projecting *into* the analyst in a way which affects the analyst. (Segal, 1977, p. 82)

Projective counter-identification: Grinberg (1962), endorsed by Segal (1977), described patients who felt the analyst was making violent projective identifications into them. This sensitivity of the patient is based on the early experience of parents who made massive projective identifications into him during infancy and childhood. Grinberg coined the term 'projective counter-identification' for this occurrence in the analytic situation.

(5) **The analyst's mind as the patient's object.** In recent years it has steadily emerged how sensitive patients are to the analyst's feelings and the analyst's methods of coping with those feelings, defensive or otherwise. Because one of the implications of the cycle of projective and introjective identifications is the process of modification in the analyst, who is required to have the stability of mind to cope with intolerable anxieties without becoming overly disturbed himself, it is in fact the patient's perceptions of the analyst's ability to modify anxiety that is really the important component. Rosenfeld (1987) and many others have drawn attention to this. For example, in discussing timing of interpretations, Rosenfeld wrote:

> In some situations one can interpret *too* quickly what one has recognized, with the result that the patient experiences what is said as a rejection of him . . . the analyst has been experienced concretely as expelling the projected feelings and so expelling the patient as well. (Rosenfeld, 1987, p. 16)

Brenman Pick, in a detailed examination of this issue, stated: 'The patient receiving an interpretation will "hear" not only words or their consciously intended meaning. Some patients indeed only listen to the "mood" and do not seem to hear the words at all' (Brenman Pick, 1985, p. 158). Would that it were as straightforward as Money-Kyrle's 'silent piece of self-analysis'! In discussing a very disturbed patient, Brenman Pick emphasized that this problem '. . . involves a massive effort in managing one's feelings, and that even in so ill a patient, enquiry was, I believe, being made into the question of how I coped with my feelings' (p. 163). The significant external object for the patient is a mental one, not a physical one; it is the analyst's mind and the way it works [see REVERIE, CONTAINING]

Working through in the countertransference: The countertransference is now an important instrument for understanding the transference; the experience of the analyst as having experiences to work through for himself in his own mind has developed, and it is now understood that the mind of the analyst, with its fallibilities as well as its interpretations, is an extremely important aspect of the *total situation* (Joseph, 1985). Previously (in the 1940s and 1950s) the patient's objects were conceptualized as parts of the analyst's body (especially the breast and penis).

Latterly, however, it is realized, the part-objects to which the patient relates and into which he or she projects are parts of the analyst's mind, at least in neurotic patients:

> I have been trying to show that the issue is not a simple one; the patient does not just project into an analyst, but instead patients are quite skilled at projecting into particular aspects of the analyst . . . into the analyst's wish to be a mother, the wish to be all-knowing or to deny unpleasant knowledge, into his instinctual sadism, or into his defences against it. And above all he or she projects into the analyst's guilt, or into the analyst's internal objects. (Brenman Pick, 1985, p. 161)

The patient's acute awareness of the analyst's mind and its contents and functioning led Brenman Pick to describe the psychoanalytic encounter thus: 'If there is a mouth that seeks a breast as an inborn potential, there is, I believe, a psychological equivalent, i.e. a state of mind which seeks another state of mind' (p. 157) [see 1. TECHNIQUE].

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Creativity

The creative achievements of human beings, who are endowed, at the outset of life, with base instincts, were always of interest to Freud. He coined the term 'sublimation' to denote the transmuting of a basic instinct for biological satisfaction into an exalted form of conduct and civilized achievement in the 'sublime' and non-physical world of symbols. For

Klein, creativity was a very much more complex process. It is not the simple transmuting of an instinct. Instead, there are several strands in Kleinian thought relating to creativity.

(i) Reparation: Klein herself wrote a note about the creative process in 1929, describing it *in relation to* a destructive attack on or by persecutors in phantasy. The creative effort was a subsequent attempt to restore the damage to objects felt to be external or internal. In that paper Klein used the term 'reparation' for the first time, and thereafter creativity in Kleinian writings has tended to be seen as a manifestation of reparation. The concept of reparation gained considerably in its significance when Klein introduced the idea of the depressive position [see 10. DEPRESSIVE POSITION; REPARATION]. Much of subsequent Kleinian interest in aesthetics (Segal, 1952, 1974; Stokes, 1955) has focused on the key role of reparation [see SYMBOL-FORMATION].

Creativity represents an essential part of the interaction in which the libidinal drives are brought into prominence over the destructive ones. In the process of investigating the nature of thought and of theory creation, Bion (1962) described, in his own terminology, the kind of unconscious activity that he discerned in Poincaré's account of scientific creativity. That entailed a loosening of all the links that bind the elements into a theory, with a subsequent repatterning around a new focal point, for which Bion took from Poincaré the term 'the selected fact'. In this Bion saw a process which he described as a movement towards the paranoid-schizoid position (loosening of integration) followed by the reorganizing around a new point, a nipple, that brings the parts together again in a movement back towards the depressive position. He represented this by the symbol Ps-D [see Ps-D].

(ii) Play: However, there are other important aspects of creativity, not often referred to directly. In her early work Klein dwelt a great deal on the nature of play as an *externalization of phantasy activity*, particularly unconscious phantasy. Unconscious phantasy is the basic building block of the mind itself [see 2. UNCONSCIOUS PHANTASY] and represents not only the unfolding of instinctual impulses within the mental field, but also the attempts to overcome the conflicts and pain to which the instinctual drives give rise. The process of externalization is part of this activity to create a more congenial psychical world. In the act of play, therefore, the child – and, indeed, the playful adult – is rehearsing, in a public and symbolic way, much of the basic pain of the human situation and exploring new solutions for it. The act of play itself is a creative process. Part of this process is the search for new objects towards which some of the impulses can be turned, thereby diminishing the internal tensions and conflicts.

Klein's notion of play was formed to a major extent from Freud's writings – Little Hans (1909), the *fort-da* game described in *Beyond the*