

A Kohutian perspective on the foreclosure of the Freudian transference in modern British technique.

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Some virtues of Kohut's approach

There are many aspects of Kohut's contributions that can be viewed as immensely valuable. His emphasis upon the role of empathy and the selfobject function in childhood development and in the analytic process has more than proved its importance, as attachment studies have revealed the crucial significance of the 'dyadic regulation of affect' and many forms of personality disturbance have been shown to be disorders of affect regulation (Mollon 2001a). Neurobiology has amply validated Kohut's perspective on the relational nurturance of the brain as well as the mind – showing that the main attachment figure does indeed function as a regulatory part of the child's self-system (Mollon 2001b; Schore 1994). Kohut's notion of 'transmuting internalisation' whereby externally provided psychological functions are gradually internalised to form the structure of the self, his articulation of the line of development of narcissism, with its bifurcation into the poles of mirroring and idealising, its role in the formation of the self-structure of persisting goals and ideals - and his outline of the vertical split in the psyche of narcissistically disordered patients – all these have been outstanding and original contributions with the ability to transform the clinician's practice in myriad benign ways. There is no doubt in my own mind that working in accord with Kohut's empathic perspective, the active use of the imagination to understand the world from the patient's point of view, leads to better results than working otherwise.

Kohut's concepts of the self and the selfobject can strike some as obscure. However, there are many places in which he describes these with delightful clarity and simplicity. For example, in his Chicago Institute Lecture of 9th May 1975, he remarks:

“... what we recognise in the narcissistic personality disorders is that there exists within us a central configuration in the personality, something we experientially recognise as our self, something that gives us the feeling of hanging together as a unit in space, something that gives us the feeling that we are continuous along a time axis ... This kind of life-sustaining structure maintains us, and, if it is massively or protractedly lost, we may collapse into the most severe forms of psychopathology known – the psychoses. ... It can be ... conceptualised from what we can now reconstruct, from the reactivation of self pathology in the transference ... when we recognise that every human being is born into a matrix of empathic responsiveness that comes from what the grownup, external observer knows to be another person, but that the child simply experiences as part of himself. The experience of the other as part of a functional self is what we now call the self-object experience. It is the subtlerepeated interplay ... of empathic or nonempathic responses to the child's needs by the important self-objects that leads to the laying down of either sufficient structure in the child or to faulty structure”. [336-337]

In Kohut's clinical illustrations, there is a recurrent motif of a vertical split, whereby part of the developing child's psyche becomes enmeshed with the mother's narcissistic desire for a child that will fulfil *her* grandiose desires – a false (grandiose) self¹ – whilst on the other

¹ This is the structure that Kernberg called the 'grandiose self', whereas Kohut (1971) used this term to refer to a

side of the vertical split, a state of mind of apathy, low self-esteem and depression, covers a repressed true 'grandiose self'. Often this is associated with a psychological absence of the father as an effective alternative to the mother, and as a vehicle for the transmuting of the idealising pole of narcissistic development (Mollon 1993). Under the nurturance of the empathic analytic ambiance, the true grandiose self might tentatively begin to express its potential, seeking mirroring responses from the analyst. It is a crucial but subtle point that, contrary to popular impression, Kohut did not advocate 'mirroring the patient'. He would, of course, analyse the patient's needs for mirroring and the reactions to failures of mirroring. In his Chicago Institute Lectures (1996) of June 6th 1975, he remarked:

"And once again let me remind you that you don't have to mirror the patient to be effective as his analyst. That is really a total mistake. The meaning of mirroring, the essence of that concept, is not that you have to play-act with your patient and praise him and respond to him and say that he is wonderful. No such nonsense. But you do have to show the patient over and over again how he defensively retreats because he expects that he will not get what he wants and that he doesn't dare to let himself know what he wants. And it is clearly the normal response of any human being to another (in this instance the analyst to the patient) to be pleased with his progress or to respond to it in a perfectly reasonable way. No more is needed. Any patient who gets an unrealistic overdose of praise ... will be affronted. He will very soon be very angry at you." [373]

The vertical split, and the enmeshment of part of the personality with the mother's grandiose aspirations, can be found commonly in clinical practice. It is a more precise and useful formulation than Winnicott's (1960) concept of the 'false self' – and is a perspective I have elaborated in my own account of 'psychic murder syndrome' (Mollon 2002).

However, a less commonly recognised treasure in Kohut's work is his careful use of the concept of transference, rooted in Freud, yet extended and modified to take account of his own observations of the selfobject transferences. Part of what makes Kohut's contributions so valuable is that he had a profound and clear understanding of Freud. Kohut and Seitz (1963) and Rubovits-Seitz (1999) show Kohut's grasp of the origins of Freud's broader concept of transference (Freud 1900), as a penetration of unconscious contents into the preconscious and conscious mind. These might be viewed as 'topographic' transferences, whereby content leaks from one area of the psyche to another. The more specific transference of infantile images of the past onto the present figure of the analyst might be considered the 'historical' transference (although the 'past' images are alive in the present unconscious). Later, Kohut identified the selfobject transferences whereby the patient is attempting unconsciously to establish a systemic functional connection with the analyst, whereby narcissistic equilibrium, affect regulation, and soothing are sustained sufficiently to allow the aborted developmental processes of the self-structure to be re-engaged. The fusion of the words 'self' and 'object' denotes the formation of a functional psychological system from the combination of functions of self and the (caregiving) other; it is not a fusion of identities of self and object. For Kohut, the historical and selfobject transferences interweave, being different aspects of the penetration of infantile needs and pathological experiences into the experience in the present. The competitive struggles of the Oedipus complex co-exist (and may be energised by) the earlier selfobject needs for empathy-based experiences that promote the development of self-structure.

The combination of the original Freudian (topographic and historical) concepts of transference, with the addition of Kohut's concept of the selfobject transference, forms a powerful lens and technical instrument to facilitate an optimum psychoanalytic process. I

call this the Freud-Kohut view of transference.

Kohut's psychoanalytic approach differs markedly from that prevalent in Britain. Here there is (as I perceive it) a dominant assumption that a continual focus on the 'here-and-now' relationship between patient and analyst should form the primary fabric of the psychoanalytic tapestry. Allusions to the 'there-and-then' are to be made very sparingly, since they run the risk (so the argument goes) of being a collusive retreat from the most pressing unconscious anxieties experienced in the present. Moreover, the focus seems to be predominantly on the *negative* transference, the patient's hostility and destructive endeavours in relation to the analyst and the analyst. Of course, not all UK analysts share this stance – and certainly not those who have been strongly influenced by historical figures such as Balint (1968) and Winnicott (1960), who emphasised a non-intrusive stance and a facilitating environment, nor by notable contemporary analysts such as Casement (1985), Parsons (2000), and Bollas (2007), to name just a few. However, the underlying assumptions and emotional tone of Kohut's work are so far removed from those prevalent in Britain that his work has scarcely made any impact there. Since he was writing against a backdrop of classical drive psychology, characteristic of the U.S.A but not Britain, his work would seem to many to be essentially irrelevant. Given the startlingly creative and liberating nature of Kohut's contributions, this is unfortunate.

Some brief indications of modern 'here-and-now' technique in Britain.

Extensive discussion of clinical material provided by colleagues can be interesting but may also obscure the simplicity of basic principles. Therefore, in order to give the reader some indication of common contemporary trends in British psychoanalytic practice, I will refer not to actual content but to the general nature of the interpretive content in a recent paper presented at a psychoanalytic forum in London.

The paper concerned two analyses that had not gone well and had led to abrupt termination. In the case of one patient, the analyst reported four interpretations within the detailed material. Two of these concerned the idea that the patient was trying to evoke a particular state of mind in the analyst – of anxiety, dread, or shame. A third interpretation suggested the patient was attempting to obliterate the meaning of what the analyst had said. The fourth focused on describing the patient's state of mind and the mood of the session.

In the second case, six interpretations were reported. One concerned the idea that the patient was attempting to discredit the analysis and show that it was useless. Another expressed the patient's criticism of the analyst's technique – acknowledging a sort of mutual discrediting. A third continued the analyst's acceptance of the patient's criticism (apparently leading to a warmer and more thoughtful atmosphere). The fourth focused on how the patient seemed to dwell upon the analyst's faults – a point addressed also in the fifth interpretation, which commented upon how the patient would keep perceptions of good and bad separate. The sixth interpretation was that the patient was getting rid of the analyst so that he would not be missed. Similarly, the seventh interpretation concerned the patient suppressing a childlike longing in relation to the analyst. The final, eighth interpretation was of the patient's determination not to allow the analysis to proceed.

Of course, a schematic reporting of an analyst's interventions does no justice to the complexity or difficulty of the analytic encounter, nor does it provide the clinical material upon which the interpretations were based. However, what is nevertheless revealed in this way is that none of the interpretations corresponded to the Freudian concept of

transference, even though all were focused on the interaction between patient and analyst.

The focus on the present interaction and the absence of historical developmental link is a deliberate part of the technique of many British analysts. For example, Malcolm [1986] states:

“The transference is an emotional relationship of the patient with the analyst which is experienced in the present, in what is generally called 'the here-and-now' of the analytic situation.”

and she adds:

“... so-called 'genetic interpretations', that is, interpretations that refer to the patient's past history, are not the aim of analytic work ...” and that “what should be the centre of the interpretation .. [is] the immediate relationship between analyst and patient, with its verbal and non-verbal expressions” [p 73-74].

Malcolm also states that for her “the knowledge of 'projective identification' is central to the understanding of the analytic material” [p 74] She formulates the process of analysis in terms of the patient's changing relationship to his or her internal objects:

“The patient, by repeating with us again and again his problems with his internal objects, portrays in the analysis the way that his relationship with those objects evolved. The interpretations mobilize defences which correspond to the old defences used in infancy and childhood.... As we interpret the present, the patient's relationship to his internal objects change, revealing bit by bit under our very eyes how those relationships were built up”.

For Malcolm, by analysing the transference in this way, the analyst is “analysing past and present at one and the same time”. [p 87]

A highly influential paper advocating a here-and-now technique is that of Joseph [1985]. In discussion of a patient called N, she reports seven interpretations. Four of these relate to the idea of some kind of war going on between patient and analyst – e.g. “apparent insight was being used against progress in the session, as if a particular kind of silent war against me was going on, which I showed him” [p 66]. The fifth concerned the analyst's perception that the patient resented the shift in his feelings, losing a sense of excitement, whilst the sixth elaborated this in terms of the patient feeling seduced out of his previous state of being stuck – and the seventh postulates that the patient projects his positive feelings into the analyst so that he does not have to feel them. Joseph hypothesises that the patient shows a “willing involvement with misery and problems rather than meeting up with his helpful and lively objects ... The analysis, interpretations, breasts, are turned away from, when they are recognised as nourishing and helpful” [p 68] Joseph sees “the transference as a relationship in which something is going on all the time, but we know that this something is essentially based on the patient's past and the relationship with his internal objects or his belief about them and what they were like.” [p 69]

Freud's view of transference

Much of Freud's later theorising is foreshadowed in his 1895 *Project for a Scientific Psychology*, whose concepts he continued to elaborate throughout his work (even though he did not subsequently make reference to it. There he described the 'false connection' or 'hysterical proton pseudos' [p 352] that formed the basis of his concept of transference. He gives the clinical example of Emma, a woman who was afraid to go into shops alone. A memory from age 12 was of running out of a shop in fright, thinking the male shop assistants were laughing at her clothes. Behind this was an earlier repressed memory from age 8, of a shopkeeper grabbing at her genitals through her clothes and laughing. Freud explains that she had made a hysterical 'false connection', linking her fear, that derived from the earlier incident (and now energised by her adolescent sexuality) to the idea of

clothes and laughter from the later shop assistants [p 355]. This notion of the false connection, the transference of a quantum of energy or affect from one idea to another, formed the persistent core of Freud's theorising about neurosis – and for him there was never any essential difference between the mechanism behind a neurotic symptom and the 'transference neurosis'.

Freud's earliest use of the term 'transference' is in the 1895 *Studies in Hysteria*, where he writes that "Transference onto the physician takes place through a false connection", which he states "is a frequent, and in some analyses a regular, occurrence". [p 302] – his example being an instance in which a patient experienced a disturbing wish in relation to the analyst that had originally occurred in the past, in another context, and had been repressed. Earlier in the same text, in an extended footnote, Freud writes more about 'false connections', which arise from a "split in the content of consciousness" [p 67] – his examples being where an unconscious idea, impulse, or mood state, is falsely explained (by the patient) by reference to an idea that is conscious.

Kohut & Seitz (1963), in a paper based on Kohut's lectures on Freud to the Chicago Psychoanalytic Institute, point out that Freud used the term 'transference' originally (1900) to refer to the influence of the primary process upon the secondary process, the penetration of unconscious contents and forces into preconscious thoughts, feelings, or wishes. Thus in dreams, transferences from the unconscious to the preconscious attach themselves to day residues. This was essentially an endopsychic rather than interpersonal process. In *The Interpretation of Dreams*, Freud wrote:

"We learn that an unconscious idea is quite incapable of entering the preconscious and that it can only exercise any effect there by establishing a connection with an idea which already belongs to the preconscious, by transferring its intensity on to it and by getting itself 'covered' by it. Here we have the fact of 'transference', which provides an explanation of so many striking phenomena in the mental life of neurotics." [SE.V 562-63]

In the same text, Freud describes how transferences are new editions of inaccessible experiences of childhood. He quotes his remarks to a patient:

"A few days earlier I had explained to the patient that the earliest experiences of childhood were 'not obtainable any more as such' but were replaced in analysis by 'transferences' and dreams." [p 184]

Freud's later use of the term 'transference', to refer to the misinterpretation or misperception of the analyst due to the intrusion of feelings and attitudes associated with important figures from the analysand's childhood past, is really a sub-category of this broader psychological process. Thus, in 1905 he wrote:

"What are transferences? They are new editions or facsimiles of the impulses and phantasies which are aroused and made conscious during the progress of the analysis; but they have this peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the physician". [SE VII p 116]

He explains their role within psychoanalysis as follows:

"In psycho-analysis ... all the patient's tendencies, including hostile ones, are aroused; they are then turned to account for the purposes of the analysis by being made conscious, and in this way *the transference is constantly being destroyed*" [SE VII p 117 italics added]

My impression is that although Freud noted that transferences *in general* (and in the plural) were essential features of neurotic processes, he did not consider the *specific*

transference to the analyst as the single essential and crucial focus of analysis as is commonly considered today. For Freud, the analyst would be "listening with evenly suspended attention" as the patient followed the "Fundamental Technical Rule" [1923 p 238] of being required to "put himself in the position of an attentive and dispassionate self-observer, merely to read off all the time the surface of his consciousness ... not to hold back any idea from communication" - and in this way the analyst would "catch the drift of the patient's unconscious with his own unconscious" [1923 p 238-9]. This broader attention to transferred feelings, images, and memories, from the unconscious to a *variety* of preconscious ideas, to be discerned by the analyst's unconscious, seems a different activity from the more interpersonal modern focus of attending predominantly to the patient's mode of relating to the analyst. To support this view, I would like to quote from Freud's *Beyond the Pleasure Principle*. I have found that analysts often react with surprise, or even disbelief, to this quote.

The quote is from pages 18--19 of the SE XVIII *Beyond the Pleasure Principle*, 1920.

"Twenty five years of intense work have had as their result that the immediate aims of psycho-analytic technique are quite other to-day than they were at the outset. At first, the analysing physician could do no more than discover the unconscious material that was concealed from the patient, put it together, and, at the right moment, communicate this to him. Psychoanalysis was then first and foremost an art of interpreting" [p 18]

Freud then goes on to say that "this did not solve the therapeutic problem". The patient's resistances to remembering could not be sufficiently overcome - and that "the aim that what was unconscious should become conscious - is not completely attainable by this method. The patient cannot remember the whole of what is repressed in him, and what he cannot remember may be the essential part of it."

Now I will quote in full the passage that I believe illustrates the contrast with modern technique – and how the latter has become, in certain respects, the precise opposite of Freud's.

"He [the patient] is obliged to *repeat* the repressed material as a contemporary experience instead of, as the physician would prefer to see, *remembering* it as something belonging to the past. These reproductions, which emerge with such unwished for exactitude, always have as their subject some portion of infantile sexual life - of the Oedipus complex, that is, and its derivatives; and they are invariably acted out within the sphere of the transference, of the patient's relation to the physician. When things have reached this stage, it may be said that the earlier neurosis has now been replaced by a fresh 'transference neurosis'. It has been the physician's endeavour to keep this transference neurosis within the narrowest limits: to force as much as possible into the channel of memory and to allow as little as possible to emerge as repetition. The ratio between what is remembered and what is reproduced varies from case to case. The physician cannot as a rule spare his patient this phase of the treatment. He must get him to re-experience some portion of his forgotten life, but must see to it, on the other hand, that the patient retains some degree of aloofness, which will enable him, in spite of everything, to recognise that what appears to be reality is in fact only a portion of a forgotten past. If this can be successfully achieved, the patient's sense of conviction is won, together with the therapeutic success that is dependent on it." [p 18-19]

I think it is clear from this passage and the context that Freud was here describing his current view as to best technique. Here I will quote again in bold the crucial sentence: **"It has been the physician's endeavour to keep this transference neurosis within the**

narrowest limits: to force as much as possible into the channel of memory and to allow as little as possible to emerge as repetition"

Of course, by 'memory', Freud is not referring necessarily to externally observable events, but to developmentally earlier *inner* situations of phantasy, desire, and anxiety.

It seems that the modern British technique reverses this stance. The current approach appears to be 'to force as much as possible into the channel of transference', and focus relatively little upon the channel of memory. The usual arguments in support of this stance are that to do otherwise is a defensive and collusive escape from the heat of the 'here and now', that all we can observe directly is the present, and that only conflicts addressed in the lived experience of the 'here and now' can be resolved. However, the converse danger is rarely addressed,; that by focusing extensively upon the 'here and now', without regularly linking this to the past, the patient remains unaware that his or her transference is indeed transference, a memorial intrusion from the past, rather than reality. Thus the transference is not (as Freud advocates) 'constantly destroyed' [1905 p 117].

Two implications are apparent from the above quote. First that Freud viewed transference as the patient's way of remembering. Second, that he thought the transference was not actually to be encouraged, although it was inevitable - the memorial material emerging as transference is to be guided back into the realm of memory. It is an endopsychic rather than interpersonal source of disturbance. Thus Freud emphasised that the transference is *not real*, and that the patient is to be helped to see that it is not real:

"He [the analyst] must get him to re-experience some portion of his forgotten life, but must see to it, on the other hand, that the patient retains some degree of aloofness, which will enable him, in spite of everything, to recognise that what appears to be reality is in fact only a portion of a forgotten past"

Lest it be thought Freud's stance here applied only to an earlier phase of his thinking prior to the structural model, I will quote from his last work, *An Outline of Psychoanalysis*:

"The danger of these states of transference evidently lies in the patient's misunderstanding their nature and taking them for fresh real experiences instead of reflections of the past ... It is the analyst's task constantly to tear the patient out of his *menacing illusion* and to show him again and again that what he takes to be new real life is a reflection of the past" [1940 p 176-7 italics added]

Thus it would appear that the Freudian analyst would seek to free the patient ultimately from the 'transference illusion' - help him or her to realise that all of what had transpired within the analysis, and which had seemed so full of passion and turmoil, was mere phantasy, a kind of dream, a portion of infantile life that had distorted the experience of the 'here and now'. The patient would be enabled to wake up from the neurotic dream and view the present with less distortion. By contrast, it seems to me that the modern technique may, in a sense, do the opposite of this - encouraging a perception of the transference as real. What Freud presented as an endopsychic process is now viewed as an interpersonal process – a real part of the psychoanalytic interaction. In this modern view, the 'transference', now seen as the playing out of the patient's psychopathology, is to be resolved in the real relationship with the analyst. The distinction between the real relationship and the transference relationship becomes fuzzy or even obliterated.

A clear statement of a contemporary position is given by Bateman and Fonagy [2004]. Juxtaposing their approach with the classical one, they state:

"In contrast, the 'modern' view sees transference not so much as the inexorable manifestation of unconscious mental forces, but rather as the emergence of latent

meanings and beliefs, organised around and evoked by the intensity of the therapeutic relationship. In clinical application there is a de-emphasis upon reconstruction.” [p 207]

Whilst coherently expressed, and probably corresponding to the implicit perspective of many analysts in Britain, this modern view of transference is different from Freud's concept of the 'false connection', the mis-perception “that what appears to be reality is in fact only a portion of a forgotten past” - an illusion that is to be “constantly destroyed” by the work of psychoanalysis.

If 'transference' is now seen merely as the *continual* expression of the patient's object relational world in relation to the analyst, rather than a more *occasional* emergence of “a forgotten past”, then it would follow that there is nothing other than transference to address – indeed nowhere else to go and nothing else to talk about. There is no intrusion of past into the present, no penetration of unconscious contents into the preconscious, and no viable distinction between transference and the real relationship. However, the cost of this modern perspective is that the Freudian transference, of 'false connection' and 'menacing illusion', is foreclosed – excluded from the contemporary discourse, along with the original focus on reconstruction. From a Freudian perspective, interpretation of transference and reconstruction of the developmental past go hand in hand, two sides of the same technical coin – each informing the other and neither making much sense without the other¹. It is a matter of reworking the past through its transference into the present, but depending crucially upon continually dissolving the illusion by means of identifying its source in the developmental past.

Could there be negative consequences for clinical work in the loss of the Freudian perspective? I suggest four that may be possible (although they obviously do not inevitably follow). [1] The privileging of the 'here and now', both in theory and technique, may obscure the significance of childhood traumas and impede their exploration through their disguised unconscious expression in the transference. [2] Since the modern view emphasises the playing out of the patient's inner object relational world in the relationship with the analyst, there is no need to wait for unknown and unconscious meanings to emerge through free-association – the meanings are all potentially available (to the astute analyst) in the manifest content of the session. This could, however, mean that more hidden unconscious meanings are not discovered, since free-association is replaced by a continual examination of the relationship [Bollas 2007]. [3] The diminished focus on reconstruction and absence of a continual movement between past and present, could mean that the patient feels trapped in a fused past-present claustrum, from which the 'third party' of history has been excluded from the analytic dyad. [4] With the lessened scope for a concept of 'real relationship', the patient may have little space from which to speak outside the transference.

Clinical illustration

I offer the following sessional vignette to illustrate a simple way in which I use the Freudian-Kohutian perspective on transference.

Elizabeth is a lady in her mid-40s, married with two children, and with a successful career in a medical profession. She is in once per week psychoanalytic psychotherapy. This was the second session following a one week break, during which she had taken a skiing

¹ A common contemporary perspective explores the possibilities that the patient provides continual unconscious perceptions and commentary upon the analytic process {e.g. Casement 1985; Langs, 1979}. This does not, however, mean that the patient's discourse contains constant *transference* to the analyst.

holiday.

She begins the session by remarking that as she sat down that she felt annoyed at being there – and wondered “why am I putting myself through this? I don't want to be here” and adding that she felt she had “taken a step backwards”, that she had been feeling easier about the psychotherapy but now felt back to how she had felt originally (in the past she had described the process of talking in therapy as “like pulling teeth”) - she did not have a sense of looking forward to her sessions.

I asked what she thought might have prompted the 'step backwards'. She replied that although she chose to come here she still resented it – then adding “its like you are looking around inside my head and I'm not sure I want that”.

I commented that it seemed she was making me sound like a coercive and intrusive mother (I had in mind other descriptions she had given of her mother). In reply she said her parents were arriving to stay that night – she felt angry and resentful – but said she could not really relate to the idea of me as a coercive mother. However, she then added that perhaps she feared she might not meet my expectations. I said it sounded as if she felt I had high expectations of her. She replied that I might be “exasperated” if she did not show signs of making progress. I asked what 'progress' would mean. She replied: “Well it would be if I were less depressed – which I am, I think, less depressed than when I started here – and more insight – which I suppose I do have – but my problem is I can be quite negative – like on the skiing holiday – I can't recognise how I am getting better – I did enjoy it, but I got quite negative about the holiday – thinking “what's the point of putting myself through all this?”

I pointed out that she had used the same words about coming to her session here - “putting myself through all this” - as if in some way feeling the same about the holiday and coming here. She looked surprised as she registered this observation, then said: “Oh – I suppose that must be right then – looking down the slope, thinking 'I've got to get down there and my legs are tired' – something similar about coming here, like looking down a slope”.

She then went on to speak of wishing she had more energy, how she has consulted her doctor about it, how she feels annoyed with herself because she feels too tired to have friends over for dinner, and how this makes her feel inadequate. She said she resents having to do things for other people.

Tuning in to her mood, I said that perhaps this theme of resentment at having to meet other people's expectations and demands linked to her childhood despair at feeling that her life did not really belong to her. She replied that she thought this may be the case – then going on to speak of the same theme in relation to her husband, whom she appears to experience as controlling and critical.

Commentary

Whilst different analysts will discern different meanings in this material, here is what I think was one important aspect of the process. Elizabeth begins by speaking directly of feelings (resentment) in relation to the analyst and the therapy. My first comment to her is a simple question intended to facilitate the enquiry into her thoughts and feelings. Elizabeth elaborates her resentment in terms of perceiving the analyst as intrusive - “looking inside my head”. I comment that she appears to perceive me as an intrusive and coercive mother. Perhaps this is a premature transference link and initially she says she cannot

relate to it. However, she does refer to her parents visiting and acknowledges feeling the same resentment towards them. She provides further detail of her resentment of me by saying she thinks she would not meet my expectations. I ask about these expectations and she tells me that I might expect signs of progress, acknowledging that there have indeed been changes, but explaining more about her negative states of mind and propensity to feel resentment. She uses the same words to refer to her feelings on looking down a ski slope as she had regarding the beginning of the session. Both situations appear to be experienced as demanding too much of her – and she speaks, with obvious emotion, of her distress over a lack of energy. She would like to be more hospitable with friends but she resents having to do things for other people. I sense a deep 'characterological mood' – a sense of despair at feeling her life is not her own – and I relate this to her recurrent childhood experience. This comment seems to reach her at a deep level. She elaborates the same conflictual theme in relation to her husband. During this session, I make no interpretations, but simply enquire, listen, and offer empathic-reflective comments. Between us we arrive at a deeper understanding of how elements of childhood despair are penetrating into her current experience, in her marital and home life and in relation to the analyst. The external trigger for her increased resentment remained unclear – but this may have been essentially a response to the internal trigger of her own increased neediness and associated transference images.

Some aspects of a later session

The following session occurred a few weeks after the one reported above.

Elizabeth began by saying she had been wondering about asking for two sessions a week rather than one. I asked her for her thoughts and feelings about this. She told me she had kept postponing asking me, fearing I would interrogate her about it or say I did not have space for her. Elizabeth talked of experiencing a greater need for help in relation to her emotionally demanding work. I pointed out that often she had expressed resentment at the idea of coming even once per week. She said she thought such feelings would remain, alongside her desire for two sessions. She was aware of increased feelings of need, but at the same time thought it would be 'scary' to be too dependent on me – I might abandon her or make her feel worse or humiliate her. She added that if she felt there was a chance I would say no to her request then it would be very hard to ask. The theme of having attended a boarding school, part of the family culture and tradition, had been a recurrent focus and I remarked to her that I found myself thinking of the child she had been at boarding school, perhaps wondering what her parents' response would be if she had asked to go home. She recalled instances that seemed in line with this – and I then remarked that I had the impression of a little girl unsure of whether and where she was wanted, who perhaps had learned to suppress her wanting. Elizabeth immediately responded that it had seemed easier "not to bother wanting – and then it didn't seem to matter". She went on to speak of her place in her family, coming after three older brothers and before a younger sister. The older brothers had seemed much more vocal in their expression of their own needs and she had felt silenced by them. Then she talked of the arrival of her younger sister when she was less than a year old, commenting sadly that she had been just a baby when there would suddenly have been another baby. I commented that she had learned not to expect her own needs to be met – and that therefore her asking for another session was a bit step for her to take, since it went against her pattern of not wanting. She agreed and said with a smile that it still felt quite scary.

Commentary

In this session, Elizabeth tentatively and with courage reveals her desires to seek more of a selfobject transference relationship with the analyst. Her needs for mirroring and

selfobject responsiveness are emerging from repression, but are associated with great anxiety, derived from the original disappointments and thwarting of her needs for empathic responsiveness from her mother. Again relatively little 'interpretation' is required. Although I shared my thoughts and empathic imagining of her childhood experience, she found her own way to her early distress, and to an understanding of how she dealt with it, and how it impacted in her life now.

The interweaving of the historical and selfobject transferences

Kohut's understanding of transference in terms of the original Freudian meaning of displacement of a content from an unconscious memory to an element of conscious perception – a repetition in place of remembering – was later modified by his recognition of the development-seeking selfobject transferences of idealisation, mirroring, and twinship. It is apparent in his clinical illustrations that he wove together the transferences of repetition and the transferences of the selfobject. The patient repeats the anxiety laden experiences of childhood and also endeavours to re-engage the aborted developmental strivings whereby the analyst is the new selfobject vehicle. Thus, in *The Two Analyses of Mr Z*, Kohut describes a crucial stage of the work, during which Mr Z “was now relinquishing the archaic self (connected with the selfobject mother) that he had always considered his only one, in preparation for the reactivation of a hitherto unknown independent nuclear self (crystallised around an up-to-now unrecognised relationship to his selfobject father).” [1979 p 431] This developmental movement was accompanied by intense anxieties of disintegration, with dreams of “desolate landscapes, burned-out cities, and, most deeply upsetting, of heaps of piled up human bodies”. [431] The mother appeared in just one of these dreams – as a simple, starkly outlined image of her standing with her back to him. This dream was “filled with the deepest anxiety he had ever experienced.” [431]. Kohut and Mr Z worked on the dream for several sessions. Its simplest meaning was that Mr Z experienced his mother as turning her back on him, abandoning him, because he was moving closer to his father. Mr Z associated to various memories of his mother's icy withdrawal when he made moves towards an independent maleness. A deeper meaning of the dream related to Mr Z's realisation of his mother's “distorted personality and her pathological outlook on the world and on him”, these being features that “he was not only forbidden to see but whose recognition would in fact endanger the structure of his self as he knew it.” [432] Kohut describes the interweaving of newly emerging memories of Mr Z's father and the idealising selfobject transference to the analyst: “the emergence of the decisive, positively toned childhood memories about the patient's father was preceded and accompanied by his idealisation of me – including, as one would expect, the idealisation of my professional proficiency.” [432]

'Tit for tat' narcissistic injuries

It will be readily apparent that Kohut's approach to transference, combining an appreciation of what is repeated from the past with attention to the developmental selfobject strivings reactivated in the present, is far removed from the predominant British technique of focusing almost exclusively on the patient's pathological activity in the relationship with the analyst. Kohut would seem more tolerant of seemingly destructive activity by the patient, seeing the normality and health in it, and seeking the truth in the patient's complaints. This is apparent in his discussion of 'What are patients angry about?' in his *Chicago Institute Lectures* [1996]. Referring to times when he has experienced difficulties in work with patients, he remarks:

“ ... over the years, I've not had the feeling that serious blind spots were my major difficulty. No, my major difficulties undoubtedly always related to my own narcissistic vulnerabilities with patients. ... I'm referring to those times when the patient gets under your skin” [p 14]

For Kohut, it was to be expected that patients would find the beginning of analysis to be narcissistically injurious:

“... it comes in the most general way from having to give up control, of not being in charge, of having somebody else lording it over you, of having someone else know more about you than you do” [15]

He would not add to the patient's shame by focusing on this as if the patient should be responding differently. Instead, he makes the following simple yet crucial point:

“The most important issue is that you don't take it personally. You know what it is all about and so you don't take it personally. Then you can be of help to the patient.” [15]

Kohut grasped that the narcissistically injurious nature of psychoanalysis is such that it is to be expected that the patient will be angry – and that in this anger, he or she will attack the analyst:

“What do people say when they are angry? Well, I think that, more likely than not, they will find some of your weak spots. If they themselves are to be vulnerable, to bare themselves, to show their own shortcomings to you in the analytic process, no wonder they want to do tit for tat and give you a dose of your own medicine” [16]

The analyst will at times feel genuinely hurt by the attacks:

“In that sense we are just like our patients. Why should we be different? You know, criticisms can really hurt and the narcissistic shortcomings pointed out to us are painful. Then we are likely to become angry and are likely to hide our anger and let our patients have it in subtle ways. But, finally, somewhere you have to catch yourself. Whenever I find myself absolutely certain that I am right, when I get that righteous feeling, and the patient is just as certain that he or she is right – then comes the time when I tell myself, now just wait a minute. So I stop and don't do anything for a while; I just listen and let the patient talk.” [18]

Concluding comments

The strength of Kohut's contribution perhaps rests partly on the combination of his innovative clinical observations, the clarity of his theorising, and the roots of this in Freud. Whilst vastly extending the scope of transference with the concept of the selfobject, Kohut retained the Freudian perspective of the historical and topographic transference. His empathic stance greatly facilitated the emergence of deeply defended against selfobject strivings, as the patient tentatively takes up again the developmental tasks thwarted in childhood.

In 1980, near the end of his life, Kohut made the following remarks at a banquet of the Third Annual Conference on the Psychology of the Self, held in Boston:

“I have a hunch that one of the reasons why all of us have to some extent lost our ability to read the current psychoanalytic literature is that it is terribly boring. We open our journals, out of conscientiousness, and we force ourselves to read. But it is a real chore. I remember that, already as a student, I would read the current literature and then rush back to Freud – to refresh myself, to participate in the activities of an original mind at work. How exciting this was! Even when I began to disagree with Freud's statements here and there, even when I recognised that his outlook was slanted at times and led to a distorted understanding of psychic life, I knew that here was a mind at work that was exciting and uplifting to follow.” [1980 p 487]

The same could well be said of the excitement to be found in reading Kohut!

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