TRANSFERENCE AND COUNTERTRANSFERENCE

A Unifying Focus of Psychoanalysis

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CHAPTER NINE

The elusive concept of analytic survival

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"At least you survived," said a colleague following my presentation at a weekly clinic meeting of a session with an extremely difficult patient. This seemingly ordinary comment stayed in my mind. The notion of analytic survival is one of those terms in common psychoanalytic currency, and it is as though we all know and understand the meaning. Trying to put aside the idea that only I did not know and understand the meaning, I thought on. How has the term been used? How has it been understood? If analytic survival has some importance in our work, in what way does it affect the patient? I considered my own clinical work, and wondered whether the experience of analytic survival was the same with each patient or whether it differed according to the nature and extent of the psychopathology and, if different, how the experience might differ.

The term "survival" is associated mainly with the work of Winnicott and his seminal paper, "The use of an object and relating through identifications" (1971). In this paper, he highlights the importance of destruction, adding that this word is needed "because of the object's liability not to survive, which also means to suffer change in quality in attitude" (p. 109). He asks again

(Winnicott, Shepherd, & Davies, 1989), does the object survive; that is, does it retain its character or does it react? A further question, then, is how, since Winnicott's time, has the understanding of survival altered?

Then there is the phrase "at least". Did this mean survival was fundamental in the analytic exchange, or did it mean that I had done the absolute minimum? These are some of the questions that I will attempt to consider in this paper.

Early indications of the importance of survival

According to Jones (1964), Freud told him more about the ending of Breuer's treatment of Anna "O" than he had written about.

> It would seem that Breuer had developed what we should nowadays call a strong counter-transference to his interesting patient. At all events he was so engrossed that his wife became bored at listening to no other topic, and before long she became jealous. She did not display this openly but became unhappy and morose. It was a long time before Breuer, with his thoughts elsewhere, divined the meaning of her state of mind. It provoked a violent reaction in him, perhaps compounded of love and guilt, and he decided to bring the treatment to an end. He announced this to Anna O., who was by now much better and bade her good-bye. But that evening he was fetched back to find her in a greatly excited state, apparently as ill as ever. The patient, who according to him had appeared to be an asexual being . . . was now in the throes of an hysterical childbirth (pseudocyesis), the local termination of a phantom pregnancy that had been invisibly developing in response to Breuer's ministrations. Though profoundly shocked, he managed to calm her down by hypnotizing her, and then fled the house in a cold sweat. [p. 203]

This recognition of transference and countertransference can be seen as the beginning of psychoanalysis as we know it today. Breuer had clearly not survived the sheer force of the transference and countertransference. Although, as we all know, Freud recommended "neutrality", there are indications in his papers on technique and elsewhere that he was concerned with the impact of the

work on the analyst. In his paper "Recommendations to physicians practising psycho-analysis" (1912e), he says that the emotional coldness is advantageous to both analyst and patient. For the doctor, this is a desirable protection for his own emotional life, and for the patient, it is the best way of helping him. Later in this paper he says, ". . . the sacrifice involved in laying oneself open to another person without being driven to illness is amply rewarded" (p. 117). His recognition of the strain of the work is there throughout these papers. In his comments on "Transference-love" (1915a), he writes of a threefold battle that has to be waged: in the analyst's own mind against the forces that seem to drag him down from the analytic level, against opponents, and against his patients. In "Analysis terminable and interminable" (1937c), he notes that the prospects of analytic treatment are influenced not only by factors in the patient, but by the individuality of the analyst, who may make use of defensive mechanisms "so that they themselves remain as they are and are able to withdraw from the critical and corrective influence of analysis" (p. 249). In a letter to Pfister (Meng & Freud, 1963), he wrote that the "transference is indeed a cross" (p. 39).

The recommendation of neutrality has been a source of much discussion within the psychoanalytic community, and there are views that it may not be achievable or desirable. However, the seeds of much that was to follow, both in theory and clinical practice, were sown in those early beginnings.

Some understandings of survival and non-survival

What, perhaps, is typical of most patients who come to analysis, is that in their life experiences, usually very early ones, their objects have not been able to provide them with an experience of survival. There may have been gross breaches of boundaries, such as sexual or physical abuse, or less obvious but, none the less, equally toxic experiences of having to become a narcissistic object for a parent, usually the mother, or of parents not being able to tolerate their development, neither separation nor individuation. Before coming to analysis, these patients usually live out their lives repeating these patterns, recreating scenarios of abuse and, of course, mostly with objects who do not survive.

A male patient, whose mother had indicated implicitly and explicitly that it was his duty to look after her, constantly made comments about whether I was all right and whether he was too much for me. During the analysis, it emerged that all his relationships followed the same pattern: he would become the carer. Exploration of whether or not I could cope with his growing dependence was accompanied by, at times, overwhelming anxiety that I would imminently collapse. Interpretation of these anxieties, in terms of his difficulty in believing that I could bear his dependence without breaking down myself, led to his telling me how, in a previous treatment, the therapist, on hearing the patient's life story, told the patient in a somewhat cosy way that she could understand the patient very well. The therapist then told the patient her life story, and the patient soon left that therapy.

Those who come for psychoanalysis or psychoanalytic therapy have, of necessity, resorted to ways of protecting themselves: through depression, self-sufficiency, compliance, drugs, perversions, or violence, to name a few. They have, in a very general sense, however, reached a point when the old ways are no longer serving them. By coming to analysis, they are seeking out an "other", be it analysis or an analyst. There are, of course, many other motivating factors, but it is the "other" that concerns us here. What this "other" might be remains to be discovered by both analyst and patient. What we do know is that this other will be, in many ways, a re-creation of others from the patient's life experience, with survival or non-survival as an aspect. From the patient's perspective, both consciously and unconsciously, there may be fears and wishes for both the survival and non-survival of the analyst. The patient, therefore, brings to analysis not only his usual ways of relating to others, but his fears and anxieties—sometimes terrors—of these usual ways being undone, as well as his expectations that there will be a repetition of many aspects of his early relationships, including non-survival, this time of the analyst. But here, the interest and emphasis is on the perspective of the analyst, what it may mean, and why it may or may not have something of value for the patient.

What Freud conveyed in his metaphor of the cross was both the idea of a very heavy burden and that this had to be borne. Since then, so much thought and attention, both clinically and theoretically, has been given to the transference and countertransference

that we are now aware of the multiple ways in which patients communicate to their analysts—verbally and non-verbally—through projection and projective identification. It is the impact of these communications on the analyst, and his reaction to it, that are at the heart of survival.

How multifarious is this impact: that is, all that the analyst has to go through (Alvarez, 1985)? My own experience echoes that of others. There is the internal resistance of the analyst himself, who is still fearful of the new and unknown, as he is only human (Bolognini, 2004). There may be a reaction of detachment in a narcissistic way (Brenman, 2006), or resistance to a loss of identity (Godbout, 2005). Potentially, there are many fears: of damaging the patient, of excessive demands, of loss of mental balance, of inability to endure catastrophic change (Grinberg, 1997), and of violent projections and recognition of our own psychotic areas (Rosenfeld, 1986).

What is evident is that the idea of "bearing" the impact needs explanation and, perhaps, elaboration. There are repeated references in the literature to "tolerance" and "non-retaliation". Bion's work on containment and reverie are relevant here (1970). Containment has tended mainly to focus on the containment of the other; the reverie, the digestion of indigestible experiences, given back to the other after a suitable sojourn, be it infant or patient. Considered less often is the question of containment of oneself as analyst.

Tolerance is a word that seems so often to be the one of choice, and it has been defined and used in a variety of ways. Carpy (1989) defines tolerance as: "The ability to allow oneself to experience the patient's projections in their full force and yet be able to avoid acting them out in a gross way" (p. 289). Cassoria (2008) writes of the analyst's implicit alpha function to tolerate patiently the obstructive movements and hindrances to recovery without giving up the search for new approaches. Reeves (2007) refers to being received, tolerated, and survived without retaliation by the mother or analyst. Sandler (1992), and Botella and Botella (2005), also use the word "tolerance". Here, however, the field opens up further. Tolerance is not simply the capacity of the analyst not to act out, not to retaliate, not to withdraw, and, importantly, not to enact a supportive or destructive role from the past. Baker (1993) suggests

that the analyst's capacity to tolerate and survive attacks obviates "the impasse that would ensue were he to endorse himself as a transference object" (p. 1227). Survival requires, at times, immense internal work on the part of the analyst including, according to some, a degree of moral masochism described by Cassoria (2008) as being similar to the mother's patience and capacity to tolerate suffering without discouragement.

When I agreed to take Mr A, a man in late middle age into analysis, I felt some reluctance in myself, and, at times, some regret at having taken him on. It was an intense emotional struggle for me, and I was aware of strong feelings of dislike, and, at times, repugnance, feelings that could translate in my mind into criticisms of him, of his dirty clothes, of his body, and minding that he "dirtied" my couch. It was some time before I could put my feelings into words in terms of his fears that I would not like him. His story then unfolded. He had felt rejected by his own mother, who found him unappealing. This took time and work on both our parts: on mine, awareness of my feelings and "tolerating" them; on the patient's, growing openness that he felt unlovable, unattractive, and unwanted.

Two ideas seem relevant to the idea of suffering without discouragement. One is the self-analytic element (Bollas, 1990) as an inner experiencing of oneself as an analyst, and the application of mind to such inner experience. The analyst must, therefore, constantly be attending to inner reactions to patients. These may include emotional reactions of anger, irritation, excitement, amusement, boredom, dislike, drowsiness, forms of acting out, such as ending sessions early, or more unconscious reactions, such as his own associations. The work of Zwiebel (2004) elaborates this in great detail, building on his premise that the central analytic task is to survive the relationship with the patient, and, further, that for the analyst to survive that relationship a third position must be developed out of the internal working processes of the analyst, over and over again. In the case of Mr A, I might have, in a simplistic way, responded to my own reactions by accepting them and believing that this was an unappealing person. Being able to question my feelings—rather than being the rejecting mother—was taking up the third position, and, thereby, surviving rather than becoming the transference object.

It is not only countertransference responses that need constant monitoring, but also many personal aspects of the analyst, including the character of the analyst, his internal conflicts, life cycle crises, and age. This includes the professional experiences of the analyst and his analytic training, including the training analysis.

The second idea has to do with another aspect of the internal work, the suffering with the patient, opening up to the patient's experience with a particular kind of receptivity. If we consider the first point, it would seem that the application of the analyst's mind to his own inner experience cannot, and, indeed, for some, should not, be an immaculate one. As to the "cannot be", Varga (2005) suggests that while the countertransference reaction to the transference must continuously be monitored, the major advance in psychoanalysis in recent years has been a better understanding of the inevitability and analytic utility of transference–countertransference enactment in the patient–analyst relationship. While there is agreement about the inevitability of this enactment, not all agree about its value. The "should not" is the valuable thought in the paper by Carpy (1989). He writes of the many ways in which acting out by the analyst might be expressed: through the choice of the area of interpretation, the type of interpretation, the actual words, and tone of voice. (We will consider in the following section in what way this might be mutative for the patient.) Slochower (1991) values the expressions of her own feeling states, saying explicitly in her clinical account that she tried to maintain an extremely firm, slightly irritated stance to the patient's barbs. Baker (2000) agrees that enactments are inevitable, while disagreeing about their therapeutic value.

The inner receptiveness of the analyst is described in various ways, including living the traumatic injured area, putting its vulnerability to the test, and adding carefully to its recovery, bearing pain and suffering (Cassoria, 2008). Cassoria compares this to the masochism of the mother, her suffering along with the baby, bearing the unreality of it, not shattering the unreality of it and detaching herself in a traumatic way. An aspect of receptiveness (Davies, 2007) is surrender to a form of controlled regression, requiring a relinquishing of verbal representations and their logical connections. Godbout (2005) goes further, describing a temporary partaking by the analyst of the experience of the other, which, if

deep enough, might shake the analyst's sense of identity. But the analyst must be able to tolerate what might be called depersonalization, allowing himself to be invaded and overwhelmed by the other. The work of Botella and Botella (2005) captures eloquently a receptiveness to the patient's psychic experience, with the analyst's nightmare mirroring the negative hallucination of the patient: "The retrogressive movement of the analyst's thought opens the session to an intelligibility of the relation between two psyches functioning in a regressive state" (p. 49). They call the psychic capacity for such movement "figurability", and its accomplishment, "the work of figurability". They remark that what "figurability" involves is nothing less than a question of psychic survival (*ibid.*).

Mrs B, a single mother who had rarely been able to put any feelings into words, was, in one session, in touch with this impediment. I felt intense strain and pressure to relieve it. She fell into a profound silence, during which I had a vivid image of a mother screaming at her. It was an extraordinary experience for me when she then said she had felt absolutely terrified and terrorized by her mother, who would lose control and rant at her.

Survival of the analyst may, therefore, not only be conveyed by the state of mind of the analyst, but also by a very particular emotional receptiveness.

Destructiveness and destruction

What, we may ask, is being survived in these analytic encounters? In his paper, "The use of an object and relating through identifications", Winnicott (1971) focuses on the destructiveness of the patient and the capacity of the analyst to survive it. There is, as a result, a move from object relating, where the other is mainly a bundle of projections. As the analytic work progresses, the object must, at one and the same time, be destroyed and yet survive, the analyst becoming "real", now to be "used" as a separate object. What is absolutely fundamental in this paper is the understanding of the meaning of destructiveness, which contains within it the thrust of aggression. For Winnicott (1950), aggressiveness is almost synonymous with activity, and part of the primitive expression of love. Importantly, at the very early stages, the infant's aim is not to

destroy, his aggressiveness only becoming destructive when there is sufficient ego integration and ego organization for the existence of anger, and, therefore, as Winnicott puts it, fear of the talion. Not retaliating, so central to the notion of survival, is, therefore, all-important in the analytic encounter.

Winnicott points out that there may be confusion in the use of the term aggression when what is meant is spontaneity. This confusion may not be only in the mind of the analyst; there may also be confusion in the experience of patients. For them, spontaneity might, in their early experience, have been received as an attack, so that it fuses with aggression, as Fonagy (Fonagy, Moran, & Target, 1993) says: if the young child's self-expression is repeatedly thwarted or misinterpreted, then his self-expression will become fused with aggression. Therefore, when forceful projections, which can be difficult and painful for the analyst to bear, are interpreted as "sadistic attacks", this can lead to the patient feeling rejected and fearing that the analyst cannot stand being involved with him. That is, the patient experiences the analyst as not surviving (Rosenfeld, 1986).

Ms C, a young single woman, took pride in never expressing emotions such as sadness or anger, which were experienced by her as weakness. However, she would continually say that the analysis was getting her nowhere, what was the point of talking, she was exactly where she had been when she came into analysis. I took this up in terms of her wishing to explore what would happen if she expressed these "negative" feelings towards the analysis and me: would I reject her and say, "Well if you don't feel it is of value, why come?", or would I try to understand her feelings with her. She said that what she did value about the analysis was being able to say these negative things to me, feeling a sense of relief both by saying them and by my response.

We often use the words "testing out" in our accounts of the patient's verbal or non-verbal "attacks", which implies that the patient is on the lookout for the survival or non-survival of the analyst, doing what Cassoria (2008) describes as the patient unconsciously scrutinizing the analyst and assessing his containing capacity. What can be overlooked in the interpretation of the aggression as an attack is the search on the patient's part for both the non-surviving and the surviving object, that there is both aggression

(spontaneity included) and love. Moreover, what is being called aggression may contain within it the resistance. As we know, Freud viewed the transference as resistance. This, according to Sandler (1992), has a self-preservative aspect, and he cautions against neglecting this aspect of resistance, which is a self-protective measure against a loss of safety and familiarity with old ways, however painful. The exploratory nature of the "testing out", the resistance, and the fact that the patient has come for analysis, speaks of the complexity of responding to such communications from the patient.

A young man in a lifelong enmeshed relationship with his widowed mother had made desperate bids to escape, not only from the mother's dependence on him, but also his dependence on his mother. He cancelled session after session, always returning contrite, anxious about my response. I might have taken this up as an attack on the analysis and me, and, in some ways, it *perhaps* was. However, I took it up in terms of his wish to explore the impact upon me of being rejected by him. Would I in turn reject him? Or would I try to understand his need to absent himself from the analysis? This interpretation needed reiteration, and I needed to contain my own irritation and, at times, feelings of rejection. Slowly, we could understand his hatred of his feelings of dependence and the power of the regressive pull to self-sufficiency, as well as his wish that I should remain sitting in my chair in the usual way, a constant and reliable figure.

Avoidance by missing sessions suggests that the patient is afraid and, if so, what is it that he is afraid of when he expresses himself in this way? Green (2008) offers a perspective by asking what people are afraid of when they are under the influence of id impulses: "They are afraid of destroying the object, disappearing themselves or destroying their own working-through processes—that means there is a breakdown as a subject" (p. 1037). This brings us back to the central theme of this chapter, the survival of the analyst as object. There may be in all patients a sense of the frailty of the object, that under the threat of the patient's self-expression, whether it is seen as spontaneity, aggression, or even love, the object will collapse. Following Green, could it then be said that non-survival of the object presages the non-survival of the subject and of the relationship?

What of the analyst's fear of collapse? From the very beginning of any treatment, there may well be a threat to the analyst *qua* analyst, a figure who, perhaps in his own mind as well as that of the patient, is on the side of change. The patient's resistance and need to protect himself by his familiar, well-worn ways opposes the analyst's core identity, and this may lead to feelings of helplessness or uselessness on the part of the analyst, which may or may not be a countertransference response. The notion of change, however, is not confined to the patient. Every analysis makes considerable internal demands on the analyst to respond to this particular patient, who has his own particular thoughts, feelings, and beliefs, his idiosyncratic responses to analysis, his unconscious ways of expressing himself, whether it is through dreams or non-verbal communications. How far can this be truly experienced, moving from tolerance, through moral masochism, to the surrender of self as described by Botella and Botella (2005)? Offering oneself as an analyst for use has a deep, devastating, and dangerous meaning. To be used by others meaningfully, we have to be ready to be destroyed by them (Erlich, 2003). Perhaps it was this that Bion in part recognized when he spoke of relinquishing memory and desire, that to be an analyst one has to give up preconceptions and be receptive to change oneself. However, while there may be change within the analyst, there is a fundamental requirement to survive, to retain his character, his analytic attitude.

When we think about the form of surrender that is required of analysts, the destruction of their identity could be experienced as a considerably high risk. The true source of resistance to the erosion of identity boundaries in analysis ought to be looked for in the analyst's fear of feeling traces of helplessness within himself (Godbout, 2005). Thus, both analyst and patient may come to the analytic encounter with fears about the survival of the analyst.

What might be mutative about survival?

Thus far, I have been considering survival as an aspect of analysis. Several questions arise from this. First, in what way might the survival of the analyst be mutative? Second, is the survival of the analyst only positive? Finally, do we need to consider the survival

of the analyst in relation to the nature of the patient's psychopathology?

"The internalization of the analyst's tolerant attitude to the contents of the patient's unconscious is vital" (Sandler, 1992). However, both survival and internalization are elusive concepts. While we may not know the precise nature of these processes, there may be room for speculation about what may be "taken in" by the patient. There are those who hold the view that "the tolerating figure, or the function of this figure can be introjected and momentarily identified with" (Joseph, 1992, p. 238). There may be the effect of the analyst's greater tolerance on the patient's superego, allowing ideas formerly repressed to be verbalized and communicated (Rycroft, 1986). Loewald (1960) and Baker (1993) emphasize the new discovery of objects:

> The essence of such new object relationships is the opportunity they offer for the rediscovery of the early paths of the development of object relations, leading to a new way of relating to objects as well as of being and relating to oneself. [Loewald, 1960, p. 225]

It is the function that is taken in, not the good object (Godbout, 2005). How, though, might the patient internalize either the tolerance of the analyst or the new object relationship?

It might be valid to postulate that, since the survival of the object is fundamental to the survival of the patient, the patient begins his analytic work in a state of acute sensitivity, albeit unconscious, to the analyst's state of mind. Fonagy (Fonagy, Moran, & Target, 1993) outlines the process whereby this capacity develops, beginning with the invitation to conceive of the analyst's mind through transference and countertransference interpretations. The patient observes and momentarily identifies with his analyst (the transference object), and is then able to explore his own mind. Here, Fonagy brings in an important aspect of "tolerance" and survival: that all this occurs in the context of a friendly and comfortable relationship. Racker (1968) has described this as reliving childhood under better conditions, and suggests that the analyst's continuous empathy, tolerance, and interpretations that reduce tension and anxiety, are all reacted to as manifestations of affection: not the need for love, but the capacity for loving. A further dimension, already mentioned, is added by

Zwiebel (2004), which may be implicit, and sometimes explicit, in the work of other writers in this field. This is the capacity to develop what he calls a *third position*. A third position is an intersubjective concept, and refers neither solely to the subjectivity of the patient nor of the analyst; it is also not a static position. It is a position that evolves, is continually in a state of flux, and is constantly transformed by the understandings of both patient and analyst. For Zwiebel, survival can only be sustained if there is an expansion of the analytic position into this third position. What is most crucial in his thinking is that while there may be what he calls derailments (non-survival), if the analyst can reflect on these the third position can be restored.

Mr C, a middle-aged patient, could not speak unless I was completely inert. A deep breath or a movement of my arm conveyed a loss of interest in him, a turning of attention to myself. This enraged him. It was as though only one of us could be alive at any one time. Either I killed him off with my aliveness, or he killed me off with his insistence on my inertia. Talking to him about this enabled me to convey that I could have a relationship with myself (the third position) *and* with him. There were ongoing derailments because I sighed and moved from time to time. What mattered was that I could understand my impact on him, his impact on me, and talk to him about it.

Tuch's (2007) view is that providing the patient with the opportunity to witness the analyst's capacity to consider how he is being viewed, as an experience with which to identify, may not be enough to prompt reflective thought in the patient. His view is that the patient needs the analyst to survive the patient's view of him, which may not be shared by the analyst; indeed, may be quite contrary to the analyst's view of himself. What Tuch conveys is that the analyst has a mind that can appreciate the relativity of perspectives.

Mr X took an instant dislike to me, and in his mind I was an exact replica of his mother: cold and critical. Due to this, there was, in the early stages of the treatment, an ongoing attack on me. It was forceful and unrelenting. I was not, for some time, able to find the right words to respond to this attack, as it seemed superficial simply to take up his aggression or fear that I was like his mother. As there was never any thought that he would like to find another

analyst, it felt as though there may have been something more positive which brought him to treatment. I eventually said, "I think you are letting me know how unlikeable I am." I felt surprised by the directness and clarity of my tone. He asked almost immediately for more frequent sessions. What seemed to matter to this patient was that I could bear his view of me that I was an unlikeable person. Perhaps it was my capacity to entertain a different perspective of myself that contributed to the patient's response. My interpretation spoke of his view of me that I did not contradict, or convey, through either my tone of voice or choice of words, could be a source of pain for me.

We return now to the question of the acting out of the analyst, understood here as conveying perhaps that he has feelings of a more reactive and less benign kind. In his work with the patient K, Cassoria (2008) describes how he showed himself to the patient to be a person who gets nervous, and that his (the analyst's) patience was not as omnipotent as it appeared to be: "When he realized that his analyst could take care of himself and not be destroyed he was more at ease with the violence of his destructiveness" (p. 170). Partial acting out, according to Carpy (1989), allows the patient to see that strong feelings are being induced in the analyst, and to observe how the analyst deals with these—that he is struggling to tolerate them. It is Carpy's belief that if the analysis is to be effective, it is necessary to convey that he is managing sufficiently to maintain his analytic stance without grossly acting out. This may link with Winnicott's (1971) thoughts on movement towards object use and the finding of an external world, which survives the patient's destructiveness, indicating a degree of change in the analyst while retaining his character.

The analyst's response to his own enactments, to what might be described as his "failure to survive", is as important as survival. Bion (1970) talks of unfortunate decisions and unfortunate interpretations in analysis, saying it would be terrible if they were never made: "In analysis it is recovery from the unfortunate decision, the use of the mistaken decision that we have to accustom ourselves to deal with" (p. 50). Both Balint (1969) and Rosenfeld (1986) recognized the importance of taking seriously the patient's observations of the analyst's mistakes. The paper by Balint is one that is rarely quoted, but one to which I referred (Berkowitz, 1999)

when considering the traumatic as opposed to the therapeutic effects of failure to acknowledge such mistakes. To be able to see oneself as failing, bear ourselves as failing mothers, is important, say Baraitser and Noack (2007). Once again, there is the notion that for the patient it is important that analysts can bear—survive—their own mistakes and fallibility, thus, not projecting these feelings into/on to their patients as their former objects might have done

Analytic survival, it seems, as the theories and thoughts of various analysts are considered, is regarded as very important, although its dynamic mechanism may not be fully understood.

For Loewald (1960), the mutative effect is to open up pathways of development that were formerly arrested. For others, it may be the development of a capacity to reflect. Whatever the ensuing process, there seems to be some agreement that it rests on the greater tolerance of the patient towards his internal objects, derived from the experience of being tolerated by the analyst, especially when the patient perceives that this is a process in the analyst with which he, the analyst, has to struggle.

Could it be said that there are different forms of analytic survival? Could survival of the analyst be experienced by some, or perhaps even by many, patients as a sense of loss? In relation to resistance, the survival of the analyst is a new and different experience, opening up the possibility of giving up familiar ways, or, in Loewald's (1980) terms, the old object relationship for a new one. He gives this further thought, outlining the impact of new organization, which impedes the return to an earlier organizational level. There could be the sense of loss of the familiar, however painful, impoverishing, or uncomfortable it might have been. He emphasizes that we need to pay attention to the importance of the connections between remembering, working through, and the work of mourning.

I have outlined some ideas that speak of the importance of the analyst's survival in terms of his capacity to reflect on his own psychic functioning, as well as that of the patient. Winnicott (1971) would seem to imply that the move from object relating to object use, one from relative merger to separateness, is achieved through the destruction and survival of the object. As Phillips (2007) points out, the most difficult aspect of human development is the changeover from object relating to object use. Why may this be so? Davies (2007),

while stressing the importance of analytic survival, draws attention to the possibility that the patient may be alerted to the terrifying possibility of the separateness of the other by the analyst's capacity to think about and verbalize his own emotional experience. Importantly, while recognizing that it may be mutative for the patient to observe how the analyst deals with his own emotions, she suggests that the notion that the analyst has an independent mind may make the patient feel more isolated, and even envious of the analyst's superior psychic capacities.

In a similar way, Tuch (2007) considers that the threat to the patient that he is being thought about—reverie—may be that the analyst cannot tolerate the full force of the "patient's being", thus leaving the patient feeling abandoned. Might it then be possible to consider that "survival" might need to be conveyed to patients in the ways that are most appropriate to them? For those who are the most damaged, to convey a sense of separateness through the verbal expression of transference interpretations, or the communication, even non-verbally, of the sense of another mind, might be overwhelming. Survival of the analyst for such patients is the analyst's surrender of a separate identity, enduring, suffering what it is like to be them. But the surrender is never total, because it is the analyst who must slowly give definition to the patient's experience as it comes into view. With less damaged patients, the mind of the analyst can come into use through language, using modes of communication suited to more complex stages of organization (Loewald, 1960).

It may be, however, that with certain patients with more severe psychopathology (borderline, narcissistic, and perverse patients), analytic survival may signify something different. Baker (2000) suggests that some patients who are severely damaged may only be able to experience their analyst as tormentors. Bollas (1987) writes of those patients who convert the analyst into a negative object who is his double, carrying his projections and identifications. An object who is differentiated is lost or a non-object. It is with these patients that the struggle to survive is hardest, described by Alvarez (1985) as frenzied efforts on the part of the analyst. For Brenman (2006), the most challenging of the narcissistic problems is the feeling of meaninglessness and futility of analysis induced in the analyst; yet, it seems right to struggle and contain. A similar sense of futility

may be experienced with some patients with perversions. The rigidity of the perversion may appear in the transference, in the form of each session being characterized by a similar rigid repetitiveness. Under the domination of their internal objects, analytic survival may pose a threat to their fragile internal world.

Mr Z, a man in his early thirties, presented with a perversion that had been part of his psychic structure since adolescence. He was seductive, charming, and false. As the therapy unfolded, the repetitiveness of his material, as though mimicking the perversion, became increasingly striking. Equally striking was his response to transference interpretations. His fear that I might actually *become* the transference object was evident, but was nothing compared to his *wish* that I would be that object. His fears that his internal objects would destroy him if he gave them up overrode his wish for something that would relieve him of his suffering. Survival, in his treatment, has had several aspects. It has meant bearing the tedium of being subjected, session after session, to repetitive themes. I have felt hopeless as the status quo has been reinstated again and again. And I have felt like part of the furniture, because he has never felt anything for another human being except a longing for appreciation. Yet, Mr Z, over seven years, feels he has made progress. He feels better about himself, his friends notice changes, he is resuming a previously successful career, is sought out by friends, and acts out very rarely. His therapy is vitally important to him. It is perhaps in a case like this that the implicit nature of the communication of analytic survival is most evident. Analytic survival that makes demands on his capacity to alter his relationship to his internal objects may threaten his psychic structure.

As to the mutative value of survival of the analyst to patients with varying degrees of pathology, it would seem that the more damaged the patient, the greater are the demands on the analyst, not only for self-analysis, but also for suspension and surrender of self to the experience of the patient. Could it then be said that the more severe the patient's psychopathology, the greater are the threats to, and the demands on, the analyst for survival?

This brings up the importance of the analytic setting in this whole question of survival. There is not only the analyst and the patient, there is the analytic setting, whose keeper is the analyst, and perhaps this should not be neglected in this discussion. The

analytic setting, with the attention to keeping the environment unchanged, from day to day, even from year to year, the regularity of the sessions, their frequency and length, the rituals that commonly become established within an analysis, all offer an aspect of "survival" of the analyst. This, too, is a communication, albeit implicit, that the structure, with its constancy and continuity, is not destroyed. The setting for some patients may well be one reflection of the analyst's state of mind, and may represent the survival of the analyst (or the analysis) with less demand made on the requirement for psychic change through the use of language, especially transference interpretations. Technically, the survival of the setting may form the bedrock for the survival of the analyst.

Conclusion

The patient has a need for a mature object (Loewald, 1960), and a quiet, thoughtful state of mind (Rosenfeld, 1986). Are these counsels of perfection? Perhaps what I have been trying to consider in this paper is that, while these ideals may at times be achievable, either with certain patients or by certain analysts with certain patients, the reality is that an aspect of our work is constant attention to the deviations, those situations in which the analyst is, to a greater or lesser extent, not surviving. The use of the word "surviving" conveys more than the word "survive". It conveys the sense that survival itself is always in a state of flux.

This has been a brief overview of the concept of survival. Few papers have had the word in their title, yet it has been cited as an important factor in analytic work. As far as I am aware, no index of a book or journal has contained this word. In casual discussions with colleagues about this omission, it has raised neither eyebrows nor questions. It has felt as though it is dumb: not stupid, but voiceless.

Is it because survival is both an implicit and a ubiquitous transference interpretation in the analysis? I have tried to allude to survival implicit in verbal transference interpretations and in nonverbal communications, but it permeates much else. The rituals of analysis contribute to survival by keeping time and timing constant; the setting, too, is kept constant. As with other deviations, any alterations in these aspects are considered within the analysis, and attempts are made to think about the effect of such changes on the

patient, to think of them as deviations, not decay or erosion leading to collapse. Someone knows about them, attends to them, and keeps the structure intact. These ideas, to some extent, meet Winnicott's definition of survival described above. But to survive also means to continue, to go on, another implicit communication to patients.

When Anna O's strong feelings towards Breuer emerged, he could only react by terminating the treatment, so he did not "survive". But he did not have the benefit of his own analysis, nor of the creative understanding that Freud brought to the experience that Breuer described to him, nor all that has subsequently followed. None the less, psychoanalysis owes him a huge debt.

Is it grandiose to infer or to imply that "survival" may define the analytic attitude? It is a communication, usually implicit to our patients via many experiences, most importantly through the ongoing intention and capacity to attend to and recognize all those small and large deviations or divergences from our analytic character or analytic setting.

"At least", then, may have two meanings, and maybe more. One is that "survival" is fundamental in psychoanalysis, and that my colleague's comment was to convey that, perhaps, with all the difficulties of that particular treatment, there had been that "at least". If the analyst survives, the patient and the analysis survive. But this may give an indication of the other meaning of "survival". That it is not all there is to psychoanalysis, that there is far, far more, but without it the patient may not be able to begin the process of living, which we can assume has, for some, been arrested, and, for others, never contemplated. It is striking that the authors quoted in this paper have come from widely differing theoretical backgrounds: Independent, Kleinian, Contemporary Freudian, and Ego Psychology, and yet this quality of "analytic survival" has been relevant to all. Where they might and do differ is in their understanding of the process of living, and of how, through long, often laborious, sometimes creative work, this can come about.

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