THE INTERNAL ATTITUDE OF THE ANALYST AT WORK:
FROM FREUD’S FREE FLOATING ATTENTION TO BION’S REVERIE.

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Emily is sitting in the waiting room. This is the first session after the analyst took a three days break. Emily is 45. She gets up quickly and follows her in the consulting room. She puts her bag on the floor and starts speaking as she takes off her coat.

P. “Before we start I just want to say that I won’t be able to come on Friday. I have to go to Brisbane for work…” (and proceeds to give details about some important work commitments.)

The analyst feels that the patient is trying to reassure her that her absence is due to important reasons, she feels that her mind is spinning and she is also reminded that in supervision there was talk of how after each break Emily sets up a break of her own and how difficult has been for the analyst to see this, rather thinking that it is just a coincidence. This time it seems quite clear.

Emily continues

P. “After our session on Wednesday I had such a sense of abandonment, I just drove away sobbing… I never felt like that before…” (The analyst does not feel moved).

A. “But you come in and the first thing you say is that you will not be able to come to the session…”

P. “mm ……………….MM……………”

Silence

P. “So I removed myself from that feeling?”

A. “I noticed that every time I go away or tell you about a break the following session you tell me about a break you need to take…”

P. (shocked and with a different tone) “Is that right? Has it happened before?”

A. After the last break you told me you would be away in September. After the January break you told me about February...
Pause

P. “So it is a similar thing to my mother going away and me removing myself. Do you think?”

Pause.

P. “Similar dynamic you think?”

A. “Perhaps you feel very overwhelmed when I say I am going away. It was a terrible experience being left, out of control... you sobbed…”

P. “I felt abandoned…”

The analyst goes on talking about what it is like being abandoned and so on. The patient goes on talking about all the nice things she did during the weekend and the issue of the break got dropped.

Emily is a patient we meet frequently. Adult, highly intelligent, conveying an air of maturity and normality, apparently co-operative and wanting to change, but difficult to have real emotional contact with, and who keeps a needier and potentially more responsive and receptive part of the personality split off and out of reach of the analyst.

She talks a lot, in a way that sounds introspective and, it seems, in order to communicate with the analyst, but in fact words are used defensively to fend off the analyst, to create a barrier rather than to communicate with her.

There is a moment in this vignette when the analyst managed to make contact, and it is when Emily responds with a shocked tone, “Is that right, has it happened before?” But then the patient quickly takes charge and moves away from her feeling of shock and recognition. When she says “So it is a similar thing to my mother going away and me removing myself, do you think?” we see a highly skilled patient at work using pseudo-analytic understanding to re-establish her defensive equilibrium after having been for a minute touched by her analyst.

When the analyst respond by saying “Perhaps you feel overwhelmed when I am going away” of course she is right, but she is talking as if she had a listening patient in the room, which she has not and she does not address what is going on in the here and now, in that moment with the patient, and so the potential moment of contact is lost.

In this way a family scenario of distance is repeated and the patient maintains control of the session.

The analyst has been moved off her analytic attitude, and has responded to the pressure from the patient to collude with her own defensive system and to avoid the area of disturbance. She does not seem to be enacting but she actually is.
This is just for the sake of giving you an example, as in reality we all know that in the heated moments in the session it may not be possible to keep thinking, that it is only when the session is over that one can think about what has been going on.

With this vignette, I want to say two things:

1. Our way of working has become more complex. Today we know much more and we take into account that patients communicate to us not only in words but through projections of affects, the pressure that are exercised in the sessions, the role we are asked to play of the characters of their internal world.

2. That the analytic attitude is not a static concept, but is a concept in constant evolution, which has incorporated during the years new theoretical advances and new understanding. In my example, the development following the introduction of Klein’s concept of projective identification and the work of the neo Kleinians.

We have also come full circle: from Freud’s famous metaphor of the analyst as surgeon – “who puts aside all his feelings including that of human sympathy” - to Bion’s model, where the analyst with his personality, character, sensitivity, moral integrity, functioning or malfunctioning - becomes integral part of the system.

So I will look at this evolution which started with Freud more than 100 years ago.

HISTORICAL BACKGROUND

In 1885 a young Freud wrote from Paris to his fiancée in Vienna:

“I will come back to Vienna, we will get married and I will open rooms to treat the incurables”

He was 29 years old, he had only two or three patients a day and they did not pay much. But slowly patients and pupils start to come from Europe and from the States and lodged in a small hotel near the Berggasse where Freud lived. He had faith in the therapeutic process of the new treatment and he also sensed that his ideas would be received with suspect by the academic world. But he also knew that each analyst would have encountered enormous difficulties because of a technique complex and difficult to learn and to apply.

The talking cure, as psychoanalysis was first named, offered a message of hope in contrast to the pessimism that came with the theories of the time, which saw mental illness as hereditary or caused by degeneration of the brain. As we know, Freud was the first to deal with the problem of people who suffered ‘inside’ and no longer treated them just as bodies to heal, but rather as minds to be understood.
An important part of the psychoanalytic method - of that psychoanalytic technique which Freud already in those early days described as complex and difficult to learn and apply - is the internal attitude of the analyst.

At times such attitude is confused with aloofness or coldness, while what I mean is basically an attitude of receptiveness, of emotional availability, of sensitive tuning in, of being involved emotionally in the process but also outside enough to be able to observe and think about what is going on.

As I said, in the 19th century mental illnesses and neurosis were considered to be of an organic nature and were looked at with suspicion and revulsion by the medical profession. It is possible (Racker) that such attitudes were originated by the anxiety they produced in the doctor who did not understand them. The anxiety and revulsion on the other hand made it impossible to understand them.

Freud was able to break through this vicious circle as he faced them not with revulsion or anxiety but with a scientific spirit of inquiry. We are already seeing here an attitude which is characteristic of Freud, and which is the precursor of the analytic attitude: a spirit of observation, a scientific inquiring mind, a participation and interest together with a capacity to maintain a certain distance.

When he went from Vienna to Paris to study nervous diseases with Charcot, the star neurologist of the day - who used hypnosis to demonstrate the psychic origins of hysteria - Freud was particularly struck by Charcot’s method of working and by his scientific observations.

Freud said of him:

“Charcot used to look again and again at the things he did not understand, to deepen his impression of them day by day, till suddenly an understanding of them dawned upon him”

This is very much a method that Freud used himself and it is interesting to see how it impressed him: carrying the thoughts deep inside one's mind until all the disparate elements gets together and one is struck by a new understanding.

When in 1886 Freud started private practice in Vienna he himself used hypnotism to treat hysteria but he grew dissatisfied with it – also he was searching for the origin of the illness not just the relieving of the symptoms.

Here enters the scene Breuer who was of fundamental importance in the evolution of psychoanalytic technique and the psychoanalytic attitude. Breuer was a doctor, friend and colleague of Freud. He told Freud about his treatment of a patient, Anna O. Anna suffered from hysterical paralysis. Breuer noted that Anna became free of these symptoms when she could TALK about her phantasies and her emotions.
Breuer also used hypnosis, and while she was under hypnosis instead of giving her instructions, he asked her to talk freely, to tell him what was upsetting her and making her suffer. When awaken, Anna O could not explain the origin of her problems, but during hypnosis she could connect her symptoms and the events of her life which caused them, and the symptoms disappeared. It was the birth of what she herself named the “talking cure”.

However Breuer eventually abandoned the treatment as he could not handle the powerful erotic feelings of Anna O towards him and the jealousy of his wife toward the patient. Freud has a similar experience with a patient but he handled it differently. First he was not frightened by the emotions that the treatment arose in the patient and second he dealt with the matter with a questioning mind and a scientific attitude asking himself why this was happening.

Again we see here how the analytic attitude is taking shape, Freud is reflecting on what is happening instead of running away as Breuer did or falling in love with the patient, as many of his colleagues did. He is able to keep thinking under pressure and has enough self knowledge or modesty to believe that erotic feelings evoked in the patients were not due to his personal charm, but that they belonged – as he will discover later - to the patients’ figures of the past now transferred on to him.

Freud will now abandon hypnosis and embrace the new method, the talking cure, the spontaneous and natural talking about everything that comes to mind which he called free associations.

**THE FIRST SHIFT: FROM HYPNOSIS TO FREE ASSOCIATIONS**

This is a major shift: with the abandonment of suggestion and hypnosis Freud concludes a historical era and begins psychoanalysis, as we know it now.

Freud established a series of brilliant insights:
- The method of free association instead of hypnosis and suggestion
- The discovery of the intense bond created between analyst and patient, the transference understood as a repetition and re-experience in the analysis of the conscious and unconscious relationship with significant figures of the past
- The use of interpretations as a way of making conscious what had been repressed, thus permitting the extension of the boundaries of consciousness
- The theory of dreams.

Freud feels now in a position to write a definitive statement on technique. He will write 6 papers, which are now a classic, dealing with the major issues regarding technique.

**FREUD’S FREE FLOATING ATTENTION**
One of these papers “Recommendations to physicians practicing psychoanalysis” deals specifically with the psychoanalytic attitude. Freud advocates a technique which is the opposite of concentration: ‘a calm, quiet evenly suspended attention’ the counterpart of the patient free association, the free floating attention of the analyst. Because - I quote “as soon as we concentrate on something we become blind to something else, and instead of keeping an open mind we follow our own expectations and inclinations. We run then the danger of never finding anything new but what we already know”.

He recommends “not to concentrate on anything, not to focus, not to take notes during the sessions, not to have an aim in mind while working with a patient, as the most successful cases are those in which one proceeds with no aim and allows oneself to be overtaken by surprise,”.

He says: "The analyst must bend his own unconscious as a receptive organ toward the emerging unconscious of the patient so that the analyst’s unconscious mind is able to reconstruct the patient’s unconscious…"

Here Freud regards analysis simply as an investigation which should not be approached with any therapeutic expectancy or desire. But things are not so simple, as we know Freud also wanted to discover the origin of symptoms.

**FREUD AND BION**

If we zoom now 50 years ahead to Wilfred Bion, to a well known paper of 1967 “Notes on Memory and Desire” we can see a similar attitude to Freud.

Like Freud, Bion emphasizes the capacity to bear a state of not knowing “the only point of importance in each session is the unknown…” Like Freud, he urged analysts to forget in the session what they know about the patient, about psychoanalytic theories and about their wishes of what they hope to achieve for the patient. This will clog the mind and new understanding will not emerge.

I quote: “In any session evolution takes place. Out of the darkness and formlessness something evolves……….” In order to capture this evolution, this glimmer of new light in the session, Bion says that the analyst needs a “discipline of thoughts”, and needs to follow some rules: one is not to remember past sessions and two is to avoid the desire for cure or success. So we see that Bion – like Freud - also regards the analysis as an investigation, to be approached without expectation or desire, but again – things are not so simple as he also – as we will see – saw the analytic attitude as a maternal attitude – the mother’s reverie that contains the baby distress. Bion did not forget that the aim of the analysis is to be therapeutic.
I want to spend a few minutes on Bion’s idea of no memory and desire, as Bion is so idealized, that the risk is that such recommendations are taken literally while in fact they are a paradox, something one strives for but which cannot be reached. Also something one strives for, after having had a training; otherwise it could be taken as an encouraging sloppy work. Of course the idea of no memory and desire is important – as it is means complete availability and openness to the patient.

But memory is also important. And patients are very aware of our memory, if we remember and if we are able to hold together important external and internal factors and bring them together at the right time.

And as far as desire, which we have to take as no desire in the session while we are actually working, not everybody agrees. Rosenfeld for example distinguishes between desires for the patient’s sake, for example, desire for the patient to grow, from a narcissistic desire for the analyst’s sake: to do well, to get satisfaction, to impress our colleagues, etc.: I quote: “it seems to me impossible to destroy our desire and intention without severely damage the relationship with the patients as when we accept a patient we want to understand and to help, and we are expected to concern with that patient”.

What I wanted to say in this rather long comparison between Freud and Bion, is that there has been an evolution of the way we work, of course as theory changes, so technique changes, but we don’t have an archeological model in which new civilizations bury the previous ones: the earlier concepts have not disappeared, some are still alive, while others are not used anymore and have been bypassed by new discoveries.

One of these is Freud’s metaphor of the analysts as a surgeon, which again – as we know - is in contrast with the way Freud worked, with his deep availability to his patients, and with the image just described of tuning with the patient’s unconscious. But these are all the contradiction we meet along the way, mainly because what happens in the consulting room and what is theorized and gets written is often different.

This metaphor needs to be understood in the context of the times. We have to remember that Freud did not have the concept of the counter transference (that the affects raised in the analyst say something about the patient); he was concerned about his colleagues not being able to handle the powerful forced liberated by the analysis, as happened to many of his colleagues falling in love with their patients. The same applies to the concept of neutrality.

But nevertheless there is some truth in what Freud says here: with the analytic work we open up the patients’ minds and we make them vulnerable, we take away their defenses, it is a massive and very delicate operation, and we have a great responsibility, and Freud with these two concepts, shows how aware he was of this.
THE BIRTH OF MODERN PSYCHOANALYSIS

Freud died in 1939; Melanie Klein arrived in London from Berlin in 1926. The refugees from Vienna, Budapest and Berlin soon after.

In the shadow of the holocaust and of the second world war, a most creative conjunction occurred - between her, the analysts who migrated from Vienna, and the other formidable radical and independent thinkers which were part of the British society in the period leading to the second world war: James Strachey, Susan Isaacs, Joan Riviere, Roger Money Kyrle, Ella Sharpe, John Rickman, Ronald Fairbarn, Paula Heimann, John Bowlby and Donald Winnicott.

The drama of the second world war had a profound effect on the development of psychoanalysis. The return of soldiers from the war sparked Bion’s work on groups and on war neurosis, Anna Freud worked on war nurseries, Bowlby Spitz and the Robertson worked on the effect of early separation and lack of maternal care.

Work with severely disturbed children by Klein and Winnicott, observation of infants by Bick and work with psychotic patients by Bion, Meltzer and Rosenfeld opened up new understanding on the functioning of very early stages of the mind and of very ill patients.

Projective identification

But, since 1946 it is the understanding of projective identification which has become an enormously important aspect of our work and has added new depth and complexity to the way we work.

Klein developed the idea of projective identification during her work with children and regarded it essential to understand infantile development. She explained that there are patients who split off good and bad part of themselves and project these parts into external persons in such a way that this person became identified with the projected parts.

A very common example is when the patient’s super ego is projected on the analyst who is then seen as judging and critical and who may actually play such role.

Another example is when parents project their own sense of failure on their children, so that the children grow up insecure and always doubting of their abilities, and they are also seen by the parents as inadequate.

So now we have another dimension entering into the work: the idea that emotions and feeling can be passed from one person to another and that such transmission happens with no words and can be intuit with a careful attention on how the patient makes us feel.

We are talking about the projection of mental pain in a broad sense – an internal bad object for example feels persecuting inside so it cannot be tolerated and is split off (I mean here an
invalidating voice which says “you are not good… what is the point of doing that… who do you think you are… you never going to finish that “etc ). Projective identification it is a defence mechanism, what we can’t tolerate in ourselves we expel, we project into another person, and the other person becomes identified with it. Is a defence against emotion that are too painful or too difficult.

We all are familiar with people that make one feel rotten, or with helpers that project the vulnerable parts of themselves into others, so that everybody else is in need of help, but them. This is the risk we all know very well, if we work in the field of the helping professions.

The understanding of projective identification has widened the concept of the counter transference, and the two are closely related as it is mostly the projective identification which informs our countertransference. It is in the 50’ that the countertransference became fully recognised as a helpful source of information about the patient.

The analysis of countertransference has its problems when we try and use it in practice, because our introspection is complicated by our own defences, so part of the countertransference does remain unconscious; moreover, here we have to distinguish if the experience belongs to the patients and/or comes from our own personality.

**Projective Identification as Communication**

To the concept of projective identification as evacuation, expulsion, getting rid of something, Bion added projective identification as communication and as something that goes on all the time in all of us, so not only a defense but a way to communicate. Patients let us know something about themselves, which they are not aware of. A very common example is the mother who responds automatically to the crying of the infant, who knows what the crying is about.

For example a patient may be talking about her busy life, her engagements during the weekend, but the analyst may feel invaded by a profound sense of sadness. This is something which is not communicated with words, but is transmitted as an affect. The patient has the sadness in herself, but can’t feel it.

**An Integral Part of the Analytic Attitude: the Setting**

The setting is an integral part of the analytic attitude. Freud established the setting with the couch/armchair, the 50 minutes, the quiet and silent room with no interference from the outside world, so that intensity of the transference could develop. But we know that Freud and the early analysts had a very loose view of the setting: Freud invited his patients for meals, analyzed his daughter, lent patients money, and was possibly unaware of the consequences of such actions.
But that is as much as he knew at the time. He was learning. It was only after the 50’s, with the major emphasis on the transference/counter transference, on projective identification, and on the awareness of the child in the adult and of early states of mind, that the setting took central stage.

The work of Klein, Winnicott, and Bion on the similarity between the analyst-patient and the mother-baby relationship played an essential part. We understand now that we are working with delicate, vulnerable, extreme sensitivities and emotions, and that small things which interfere with the setting have important meaning. We understand the importance of continuity and sameness; we see the setting as an extension of the analyst’s mind and as a container of early emotions.

For example. The analyst who is late in opening the door may evoke feelings of having been forgotten, of having fallen out of his mind. A file left on the table may evoke the presence of other patients, a book moved from the bookcase may evoke an analyst who is busy writing a paper and with her mind on other things. One needs to be aware of minor nuances, in order to be able to interpret it, because in these we often find the infantile transference, the infantile aspects of the patient.

**BION’S CONTRIBUTION**

**Maternal reverie – Containing and transforming**

Bion introduced some very important concepts which had a major impact on the way we work today: projective identification as communication, maternal reverie and containment. But in order to understand it we have to go back to his theoretical innovations, as Bion was interested in thinking and what makes thinking possible. He puts the capacity to think at the very core of mental life. Not an intellectual knowing and thinking, but an emotional one, to know about oneself and others. For Bion the capacity to think evolves in the early relationship between mother and baby and depends from the introjection of a mother capable of understanding – through her reverie – the baby’s experience and to give it meaning. The classic example is that of the baby projecting the fear of dying into the mother and re-introjecting it in a form made tolerable by the mother. Reverie is similar to Freud’s free floating attention: an openness to receive, thinking about, reflecting, keeping it in one’s mind, let’s it work inside, a sensitivity, an intuition ……

So what was intolerable and indigestible gets transformed in something tolerable.

For Bion a similar process goes on in analysis between analyst and patient.

For the projective identification of both types to be understood, depends from the analyst capacity to be a CONTAINER of the patient’s projections
In the sense used in psychoanalysis, a container is someone who can receive and process projections and give it back transformed to the patient. Only if the analyst has got this capacity, the projective identification gets put into words, open to dialogue and to be understood, and in this way processed and transformed.

**EXAMPLE**

A young man Mario, comes to therapy in order not to repeat with his own children how his father was with him. He is in - once a week - therapy. Mario is psychologically minded and insightful. As it often happens, quite soon a very painful and traumatic story emerges, but apparently with no emotions on the part of Mario.

Mario had a brother with a congenital illness, who was the fathers’ favourite, and occupied mother’s care and who committed suicide when he was 18 and Mario was 16. Mario starts reporting in therapy terrible nightmares: in one he is carrying the brother in a body bag over his shoulder. The real reason of why he wants help now reveals itself: Mario needs to process what he is carrying emotionally, the brother’s body and so be able to mourn his death. The therapist reporting the session to me, says that she felt like a bomb thrown at her, out of the blue she felt an unbearable sadness, she said, “it hit me here,” on her chest, and starts crying. She said that she was able to contain her tears in the session. This happened at the end, so there was not much she could do with it, but she said: “I felt we got a lot closer talking about it, I felt like putting my arm around him,” which she did not.

I think this is an example of projective identification as communication, the patients wants the therapist to know what it feels like for him, but also what at the moment he cannot feel, as it is too unbearable. It will be the therapist's task to contain it, and slowly help him to process something that he has carried for more than 20 years.

Eventually the body bag of the dream will be transformed – thought the containing and interpreting of the therapist - into emotions, affects that the patient will be able gradually to experience, into guilt, sadness, anger and finally mourning. So he will be able to get on with his life. This is an extremely delicate work, if done too quickly, patients may find it intolerable and leave, and sometimes they leave anyway as the integration does not feel possible.

So the word ‘contain’ – as this is another used and abused concept - does not imply a passive attitude which means the analyst should sit there in silence and do nothing. On the contrary containing requires a great deal more, essentially the analyst has to be prepared to enter in an intense relationship with the patient and to allow the patient experience to enter into her and stay with her – in my example both the therapist and myself as a supervisor – we can’t forget it, we both carry it. To be able to put the patient’s experiences into words requires a great deal of active thinking and a capacity to put it all together.
REFLECTIONS- THE SILENT REVOLUTION

I would like to stop here for a minute, as we talked about a lot of concepts, and I want to underline how a shift or a silent revolution has occurred in the way we work. Of course there is lot more, but there is no time to go into everything.

You will have a sense by now that analysis is not a one side process – if it ever was – but an intense relationship in which both analyst and patients are involved, but also from which the analyst has to re-emerge to recover his thinking and to ‘consult his analytic self’ as Britton put it.

As I see it – as part of our analytic attitude – we interpret less and we explore more, by this I mean that we encourage the patient to open up the material so that it becomes a mutual process of discovery. Of course we should not idealize this aspect either, as patients have powerful defenses against discovery, as so do analysts, even if hopefully they are more aware of it.

My sense is that in the balance between containing versus interpreting, containing has got a slight edge, which in way worries me – as I consider the interpretation of unconscious phantasies quite fundamental, when needed as for example for all the oedipal phantasies.

We are also working constantly with our c/t and use our experience and affect as an essential part of our work and to gain understanding of our patients. This is also why we need a personal analysis in our training to know enough about ourselves, to be able to distinguish what is in our c/t coming from the patient from what comes from our own personality. And not to project our own unwanted un metabolized affects into the patient. As the risk is always there, we need to consult and discuss regularly our work with our colleagues and to keep our ears open to the patient’s response to what we say.

As the analyst is now emotionally involved in the relationship, his personality, character, shortcoming, become very important. How open we are, how we respond to projections, what the material evoke in us, has a lot to do with the sort of person we are. Patients of course perceive us quite accurately from the way we work. But – again – this is a fine edge- because they also see us as transference objects. Taking the transference is another aspect of the analytic attitude we did not have time to talk about.

CONCLUSION

I have given you a brief history of the analytic attitude: how it grew in Freud's mind from his clinical work and how it developed as we came to understand more in depth how the human mind works. I showed you how the main shift occurred with the understanding of the c/t and
projective identification and – as a consequence – how the mind and personality of the analyst has become an integral part of the process.

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