

## CHAPTER ONE

# Listening for the emergence of infantile dependency\*

Ultimately, a science stands or falls in proportion as it is a valid technique for discovery, and not by virtue of the "knowledge" gained. This last is always subject to supersession; indeed, supersession of findings by new findings is the criterion by which vitality of the subject is judged.

—Bion, 1997, p. 190

### *Introduction*

During the course of analytic practice—treating patients and supervising other professionals—I have found that, as a rule rather than an exception, the lion's share of today's patients come seeking psychotherapy on a once or perhaps twice-weekly basis, whether or not they are aware that they have been referred to a "psychoanalyst". Few if any

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prospective patients know much about "analysis", let alone that it is traditionally conducted four or five times per week, with the patient reclining on a couch, and the analyst seated out of sight behind them. In light of this fact, some analysts seem to suggest that we need to educate patients *about* psychoanalysis in order to encourage them to go along with the program. Some even speak about "converting" a once or twice weekly psychotherapy into a four or five times per week analysis in order to provide a "control case" for the sake of a candidate's training requirements.

However, perhaps by listening to a patient's anxieties and her needs, desires, and fears for and about closeness and dependency, and by interpreting these in the immediacy of *the transference*—and by that I mean the dynamics of the here and now relationship between patient and analyst as it is being transformed moment by moment in the hour, and as it is expressed right from the first hour of contact—we may be able to give the prospective patient a first hand experience of analysis; that is, a sampling of our capacity to closely hold and contain her both firmly and tenderly in mind.

In this manner, we may be able to convey that we *welcome* and thus may *facilitate the emergence* of the infantile aspects of the patient, which are perhaps those dimensions of the personality most in need of contact and understanding. By doing so we may also be able to relieve our new patients of their inclination to hold onto us with their eyes as well as their compulsion to stoically toughen up between what they feel must be infrequent and tenuous encounters with an unknown and unknowable stranger.

Here, I am emphasizing the need for "learning from experience" (Bion, 1962b). This must take place, right from the inception of the analytic process, if there is to be a viable atmosphere in which the patient is truly able to grow; For just as the infant, in the process of discovering the world, can find and move about out of his own sense of agency only when he feels safely held in the attention and gaze of a mother who follows his every move, so the patient in the process of discovering his internal workings—his emotions and his own mind—must feel free to explore without suffering the paralyzing dreads of becoming lost in the act of compliantly following the analyst's lead. For the analyst, knowing "about" must never supersede being and experiencing, just as the analyst's desire to teach analysis must not be permitted to supplant his therapeutic function. In the following clinical examples, I will

demonstrate how some patients may come to "feel free" to ask—directly or indirectly—for additional hours, and to wend their way organically\* to the couch, rather than to be guided there didactically by the analyst.

### Anthony

A single man in his early thirties, Anthony was referred for therapy by a colleague. During the course of our first two meetings, which took place on a Monday and Thursday of the same week, Anthony sat in a chair across the room from me. He quite calmly and matter-of-factly presented a very organized history of his "very ordinary" early childhood, education, and career, as well as a description of his relationships up until our meeting. Nearly emotionless, he ended each of the interviews right where he had begun: with a simple statement that he wanted to see a therapist because there was something that did not "feel quite right."

I suggested to him that he might be letting me know that he wished to continue with me for now, although I he did not find me very comforting, "not quite right." He smiled at me in a boyish way, seemingly pleased that I had noticed that he was not "mad about me", that I would take responsibility for bringing this up, and that I was not put off by his lukewarm reception of me.

Anthony seemed to be deeply unhappy and alone, in spite of what appeared to be an uneventful childhood and university experience, and some satisfactory—if not intimate or close—relationships with both male and female friends. I had a discomfiting sense that there were some aspects of Anthony's experience that we had not yet arrived to in these interviews, something that he was helpless to "know" and to tell me about. This feeling was especially strong in me at moments when there would be a pause in his otherwise smooth narrative. During these pauses, Anthony seemed to focus his gaze on my couch, positioned to the left of me against the wall opposite from the chair in which he sat. He said he felt "oddly comfortable" with me today, and he wanted to make another appointment for the following week, although he did not know just then what we might accomplish together.

In our very next meeting, he reported the following dream:

He is sitting in a room when he suddenly notices a baby in the room with him. He feels that he is meant to be watching over the baby as it

is lying in a crib, but he immediately senses that there is something wrong and begins to feel anxious. He notices that the sides of the crib have either been left down or are missing altogether. Only the two ends are in place. He also notices that the baby's head is not supported and it seems uncomfortable to him. He thinks that the baby needs a pillow or a cushion but wonders at the same time if very little babies can suffocate with a cushion. He looks across the room from where he sits and sees a pillow on a couch, but feels suddenly unable to move to reach it. His arms and legs feel weak and unsteady and he knows he needs help, perhaps to pull up the sides of the crib so that the baby won't fall out. He notices a woman sitting in a black leather chair, not far from him. He has some thoughts that she might be able to help, but is unsure that she would want to. He thinks "she would need to carry me over to put the sides up, but what if she doesn't want to, or perhaps she can't". He feels hesitant at first to ask the woman for help. Finally he calls out, but she can't hear him and he wakes up frustrated, crying.

After what felt like an awkward moment, Anthony said that he didn't know what the dream meant. He didn't have much experience with babies. After a brief silence, he said that the black chair in the dream was something like the one that I was sitting in. Then he paused and looked away from me, directly at my couch. He said, "You know, that's an odd piece of furniture! It looks rather like a cot, not like a couch at all". He noticed that there were no cushions at the back, only at one end. He wondered if people really lie down on "those things".

I said that it seemed that, like in the dream, there might be a baby-he who needed watching over, a little one who had suddenly appeared after our encounters last week and who I had left him alone to care for since our last meeting. I added that I thought that perhaps he'd been worrying that this baby was in danger of falling, with only the ends of the week in place. With eyes wide and an upward curve in the corners of his mouth, Anthony seemed surprised and interested in what I was saying to him. I continued, wondering aloud if he might be expressing a wish to ask for my help to secure the baby-he with two more hours per week as a way of supporting his mind and giving him both a sense of comfort and a feeling of safety. But perhaps he was also expressing a concern that I could not nor would not be able to carry him over,

and was also somewhat afraid that so much contact between us, like a cushion in the crib, might be too suffocating.

Anthony responded sheepishly, confirming that he had indeed been wondering if anyone ever came to see me that often. Then he had had the thought that he might not be able to afford to come more frequently and that I probably wouldn't agree to adjust my fee to accommodate him. He had also wondered many times during our sessions in the previous week if he could lie on the couch and imagined what it would feel like if he did, but it had seemed too scary then even to ask me about it.

After a pause, Anthony said that he had just remembered something that he had previously forgotten to mention. To my surprise, he told me that, as a baby, he had been adopted. He had been told in his early teens that his birth parents had been too young and poor to keep him and they had given him up at birth. He said that he now wondered why he had not given this much thought over the years until now. It just was what it was and did not strike him as significant.

I told Anthony that perhaps the missing parents of his birth were like the sides of the crib that were missing. Perhaps he might be telling me that we needed all four sides—four hours per week on the "cot" with the pillow—so that he could feel safe with and comforted by me while he gave some thought to these childhood losses, even though it was clear that we would need to be mindful of a baby-he that might be in danger of being overwhelmed, both by such close contact with me, and also by his feelings about what he had missed long ago and was more recently experiencing as missing.

One might see, in this example, how a dream—presented in the very beginning of the treatment—can readily be taken up in the transference; how this works to mobilize additional unconscious material while establishing a closer connection between analyst and patient, thus affording the patient an experience of the analyst's willingness to contend with a burden the patient has felt unable to bear on his own. One can also see how such anxiety-ridden issues of frequency of sessions and the use of the couch might be heard in the patient's material and addressed early on in the work.

Of course, it is not always the case that a desire for greater frequency of hours or a curiosity about the couch will develop this early in the treatment. Many patients work up to this realization more gradually, as

trust in the analyst's ability grows slowly. I will now give an example of such a case brought to me for supervision by a colleague.

### *Cora*

Cora was in the process of undergoing intensive fertility treatments—including artificial insemination—when she began analytic therapy twice weekly. Within a few weeks Cora's material began to speak to a desire for "more frequent treatments, which were needed to facilitate conception." The analyst told the patient that she thought that she was also speaking about a felt need for more frequent meetings, in order that the analytic couple might be able to conceive of a baby-Cora that wished to be brought to life in the mind of a mother-analyst. The patient was very moved by this interpretation and the frequency of sessions was subsequently increased to three per week.

During several months of treatment, there was evidence in the patient's material that she experienced herself and her analyst as "growing more and more compatible with each other." The material also spoke to Cora's sense that her analyst was becoming more receptive and "able to conceive" of her. During this time the analyst felt that she could better understand and could now begin to formulate and to transmit in a timely way some rudimentary understanding of her patient's most primitive fears. Each week, over the four-day break, the patient would become seriously depressed and hopeless and the material presented during this time seemed to throw up images of a baby being dropped, aborted, or drained away in a bloody flow.

Cora brought material conveying her sense of a womb that was not adequately constructed to sustain an embryo, which would consequently be "sloughed off soon after conception." Complaints that the fertility treatments were wasted, the money spent on these flushed down the toilet, and the feeling that her fertility doctor was not available when needed, lead Cora's therapist to interpret these communications as expressions of the disillusionment with the analyst suffered by the patient during the too-long four-day weekends, and her experience of the bloody battles that she would attempt to engage her analyst in on Mondays when she returned enraged after the break. This line of interpretation seemed to open the way for the patient to be more direct with her therapist about her discontent, and this new understanding once again seemed to be connected to Cora's request for an additional hour.

Although still sitting up, now Cora began to bring dreams of a baby needing to be held in her mother's lap and in her arms, close to the breast; of an infant with a heavy head, too little to sit up; of fears of predators attacking from behind; of a father who fondled her, and a mother who came at her in a jealous rage with a knife, while she lay prone and helpless in her bed. Taking these dreams up in the transference—as an expression of Cora's wish to be close to her therapist, to lie on the couch, as well as her fears of being vulnerable if she did so—finally enabled the patient to use the couch and the subsequent deepening of the transference relationship, in all its many positive and negative forms, was further facilitated and within a short time the patient requested a fifth hour.

### *Financial considerations*

Next I would like to speak about those patients who quite frequently become aware of their desires for more contact with the analyst early on, just as Anthony did, but who feel financially unable to increase their hours. Some might think of this as an early resistance in the treatment. But I would like to address a different problem: that of resistance in the analyst. At times the analyst may unwittingly avoid addressing such material, especially that aspect of the patient's material that speaks to the need and/or the desire for more contact. When I have pointed this out to my supervisees, they often speak to a concern that, by interpreting their patients' desire or need for more frequent sessions, they might only be tantalizing them.

The following example may illustrate the importance of "telling it like it is" with respect to our patients' psychic reality, regardless of the external reality of their situation, since an enormous amount of work can and must often be done to remove adjunct obstructions to increased contact, as these are interwoven into and bound up with an external fiscal reality. In the process, financial impediments may also be ameliorated, as it was the case in the analysis of a patient I call Lilly.

### *Lilly*

A twenty-eight-year-old graduate student, Lilly entered therapy on a once-weekly basis, referred by the clinic. However, it soon became apparent, in the material presented in the first few hours of the treatment,

that the chronic depression of which the patient complained was characterized, in part, by hopelessness about the prospect of ever achieving a close and caring relationship. The contemporary version of what I took to be an early hopelessness was expressed in terms of her relationship with a man whom she had been seeing for a number of years. She had hoped, almost from the beginning, that this relationship would lead to marriage and "having a baby". However, we soon came to understand that this also represented a deep unconscious longing for such closeness with me—a steady, analytic marriage and the creation of an analytic couple that might be capable of conceiving of and bringing to life a baby-Lilly who could then develop and grow into a creative individual. Just as Lilly's paramour had shied away from serious considerations of marriage and children because of financial deficits, seeing her only once a week, Lilly feared, in the transference, that I too might refuse to commit to a true couple-ship and to participate with her in parenting the baby-her.

My interpretation of Lilly's need and her fear that it would never be met, because she felt she had too little to offer me, seemed to diminish her sense of helplessness, and within weeks she was able to see her way clear to obtain a second part-time job in order to pay for an additional hour each week, which she also felt encouraged to ask for.

Now Lilly began to speak about her parents, who partially supported her in her graduate studies. Although she was in contact with them, she actively avoided and therefore had little to do with her younger sister, who had a lengthy history of depression and eating disorders with multiple suicidal attempts for which she had been frequently hospitalized. I took this up as pertaining to a feeling that I was only partially supporting her, referring to the two hours per week, and her feeling that this situation left a very ill sister-half of herself un-helped, left out of touch in the treatment along with a profound sense that it was I who wished to avoid contact with that part of her.

Although Lilly had at first only briefly referred to her sister and the intense nature of the competition between them, dreams as well as some memories unearthed by or alluded to in the analysis of the transference now began to aid us in fleshing out some of the complexities of this relationship with the sister and its numerous unconscious internal counterparts enacted in the transference relationship.

For example, during one Monday hour, Lilly was telling me about a growing sense that her boyfriend did not like babies. This was

troubling, as it seemed just one more piece of evidence in support of her fear that she would never have the baby she so wanted. When I pointed out to her that she might perhaps be in despair over the suspicion, which had grown in her over the breach in our contact, that I did not like the baby-her and how unwanted she had been made to feel by me, she recalled that she had never had a baby-doll when she was a child, and had been afraid to ask her parents for one. This thought reminded her that she had not been allowed to see her baby-sister until the sister was old enough to walk, and she had taken this to mean that her parents were fearful that she might harm the new baby in some way. Over a number of hours we came to understand that she had been convinced that it was dangerous for her to come directly into contact with a helpless, needy baby-part of herself, and that she had been keeping this baby-she out of sight and out of mind for protection. However, it seemed that in spite of this, there was also a Lilly who wanted to have contact with this baby-doll-sister, but was afraid to ask for it, just as she was afraid to ask for more contact with me.

Lilly went on in the same session to say that she had been grocery shopping when she noticed a girl. From behind, this girl looked so thin and emaciated that Lilly thought to herself that she must be very ill. Once the girl turned around, Lilly recognized her as her own sister, but was so taken aback by her frail condition that she hid herself from view until her sister left the store. Lilly's report of this incident lead us to better appreciate how persecuted she felt by the sight of or insight into the state of that baby-her, starved and neglected over the years, and of how she continues to hide from this aspect of herself, which perpetuates her terrible sense of guilt.

Following this session, Lilly reported a dream in which hundreds of little mice were running loose in a diner or market in which she worked. In the dream she was ordered by her "boss" to destroy the mice with a broom. At the counter was a customer playing a game of tiddledywinks. She was angry that this customer just wanted to talk, but would not help her to eradicate the mice. She was able to kill one of them, but the others got away. It soon became apparent to me, and thus I said, that Lilly was quite angry at me for not helping her to kill off her mousy, run-away infantile feelings of hunger and dependency, which a very bossy part of her orders her to destroy, and that she felt my desire to talk with her about these feelings was like some wasteful and idle

game I wanted her to play with me, but that I would do nothing to help her with her task.

One week after this session it became more clear that Lilly's sister also represented a psychotic, out-of-control, and suicidal part of her that she was terrified to associate with and was painfully ashamed of; an envious, greedy usurper that threatened to take away or, more accurately, to takeover her creative capacities; as well as a stunted or as-yet-undeveloped part of Lilly that was always holding her back.

In the transference, I soon became all of these things to Lilly. During this period, she often feared she would destroy me with her hatred; that I would take away some good experience, which she'd had in school; that she would be made to feel ashamed if someone found out that she was in treatment, or that I was holding her back in her progress in the analysis due to my incompetence. Associated with the latter, was a maternal transference in which Lilly experienced herself either as a "smart baby" who had to take care of a feckless Mother-me, educating and organizing me as well as picking up after me in my mindless incompetence, or as a "stupid, ugly, messy baby", unwanted, abandoned and neglected by the Mother-me. In this way Lilly seemed to fend off anxieties related to envy of her caretaking object (when she could experience me as dependent upon her), as well as the pain of gratitude (when she could feel that I had drained away all of her resources).

I was also experienced at times either as a diabetic Father-analyst in a state of self-inflicted coma: unconscious, mindless, and speechless (especially during my silences) or as a cruel, heartless, erratic, and incomprehensible Father-analyst (when she experienced my interpretations as abusive and meaningless). Lilly's reluctance to expose hostile feelings toward me seemed to stem from some early experience with her father who seemed to be quite authoritarian as well as physically abusive with her. On one occasion, Lilly had struck back at her father during a particularly cruel incident in which he had pushed her to the floor and kicked her. Lilly's attempts at defending herself served only to arouse further violence on the part of the father. It seemed that, during this period, Lilly's silences served as a means of protecting herself from those interpretations felt to be violently attacking of her.

Now it appeared that Lilly's initial inability to be direct with me—regarding her needs and wants and also feelings of rage in the face of the inevitable frustrations inherent in the analytic setting and the limits of the relationship—seemed to be related to a well-remembered

prohibition by her mother against "drinking directly from the milk carton." Lilly's oblique style of reporting material and responding to interpretations seemed to resemble the bent straw in the glass from which she recalled being made to drink her milk as a child. During this period, she would often report that whenever she would call home to speak to her mother, her father always answered the phone and thus she had to pass by him to get to her mother. This seemed to be a current-day representation of Lilly's sense of a circuitous contact with her mother, which always had to be screened by the father and could proceed only with his consent. It was clear that her experience of me as unavailable echoed an early experience in which the mother was compelled to put the needs of the father, as well as those of the new baby sister, ahead of the still dependent little-Lilly.

In spite of such barriers to our connection, around the anniversary of the first year of the treatment Lilly began to bring material related to themes of containment. For example, she reported seeing a "baby bag snow suit for sale in an L. L. Bean Catalogue," which approximated her dreams of being safe and warm. She imagined that there might be a feeling of claustrophobia or some constriction of movement associated with this suit, as there did not seem to be space for the hands and feet to move about freely (i.e., no adequate articulation), but mostly it just seemed to her to offer safety and warmth.

Soon Lilly began to express not only her angry feelings toward me, but also the sense that I could contain some unbearable excitement that she had experienced regarding some very positive developments occurring at that time in her life. She seemed to be increasingly able to differentiate the me she experienced in the transference from the me she experienced as a new object who could be trusted to articulate and to contain rather than to distort or restrict her experience and her development.

Lilly's feelings of being held in a caring and safe ambiance in the analysis lead to an increasing awareness of her dependency upon me. In turn her increased longing for more closeness with me brought her nearer to those feelings of emptiness and loneliness and of having nothing inside during my absence. At first, Lilly dealt with this "empty feeling" by filling up her schedule, especially letting things pile up until the weekend so that she had to work around the clock to complete her school and work assignments. Although this served as an efficient way of warding off the terrifying feelings of falling to pieces, placing

enormous pressure on her—like the constricting baby-bag snow suit that seemed to act as a second skin (Bick, 1968) that held her together—a now exhausted Lilly, feeling even nearer to the point of collapse, and she began to binge on food, which helped her to feel full inside.

Around this time, there also appeared a delusional jealousy toward the baby-Lilly that could depend upon me, as well as toward the adult-Lilly who was engaged in a creative intercourse with me in the analysis. This jealousy seemed to be located in that part of the patient that felt consistently left out and ignored, having to fend for and feed herself: a part of her that was so angry that she often refused my attention and availability. This refusal often took the form of the sort of silence that seemed to help Lilly to feel “hard and mean”, rather than soft, vulnerable, helpless, needy, and defenseless.

Another aspect of Lilly’s history now surfaced to present a complicated technical dilemma. For example, as her parents had not allowed Lilly to ride a bicycle or to cross the street by herself, she always felt left calling out for help, unheard and unattended to, but also prohibited from helping herself. Indeed Lilly felt that she had not been allowed to fall—or perhaps to fail—in the normal ways children do, so that she could have an experience of being picked up and of being capable of picking herself up when she did fall. Thus, falling—stunted in its early infantile form—remained a terrifying threat to her, and she seemed to have inherited her parents’ fears on top of her own. Lilly thought that her parents—and myself in the transference—needed her to be safe for them, in order that they might be shielded from re-experiencing their own dangerous childhood traumas.

In part this experience of hers—that the parents needed her to protect them from an awareness of their own childhood experiences—seemed to be at the core of her identity and was indeed her reason for being, so much so that she seemed compelled to forfeit her own needs, including her need for more analytic hours, in favor of obligations and duties toward others. At the same time, it seemed that such rigidly adhered to commitments functioned as a secure and reliable structure, omnipotently created (Symington, 1985), within which Lilly could feel relatively safe from an overwhelmingly intense fear that “the world would otherwise come to an end.” Without this preoccupation with the needs and desires of others she was faced with an empty space to be filled with “who-knows-what.”

Possibilities were unbearably frightening for Lilly and she now experienced my silences as “the dangerous unknown.” Many times I felt compelled to say something before I even have time to know what I was thinking or experiencing with her. It seemed that she merely needed to hear my voice in order to allay her fears that I was no longer there. Perhaps this was in part an expression of her need to have me fill up the spaces between us at times when she felt she might float away off the face of the earth into nothingness. My voice was felt to hold her together at such times, regardless of the content of my interpretations (Mitrani, 1992). My understanding of this, coming just prior to a holiday break, seemed relieving to her and led to her admission that she hated to be aware that I was so important to her, since this awareness left her feeling unglued in my absence.

This period of the analysis seemed to free Lilly to think more and more clearly about her own needs, and seemed also to increase her sense of herself as a valuable person who deserved more than she had allowed herself. Subsequently she was able to seek and to find more appropriate and profitable employment and, with a dramatic increase in her income as well as her self-esteem, she was able to ask me for two additional hours.

### *Conclusion*

In concluding this chapter, I wish to briefly say something about another category of patients who not infrequently come to us: those patients who bring us the remains of a previous analysis that has ended badly, either prematurely interrupted or in a state of impasse or stalemate. In these cases we must often be prepared to be the inheritors of a ready-made negative transference, which may act as a hard and impermeable protective barrier against further analytic contact, which carries with it the threat of still more disillusionment. Such prior disappointments in analysis dare us to try to explain them away, and the pressure from the patient to do so can be intense. However, if we get caught up in that challenge, all our efforts to reassure the patient—that this time will be different—usually fall flat. The patient who comes for “therapy” to heal the wounds of a “bad experience” in analysis needs to experience the difference between past and present, rather than be told about it.

Indeed, only by sustaining a tolerant attitude and by paying meticulous attention to gathering in the negative transference right from the first encounter with such patients, can we hope to win back their confidence in analysis once this confidence has been betrayed. These last examples will perhaps serve to get my point across.

### Marc

Marc was referred for therapy after the termination of very long analysis. This was all I knew of him prior to his arrival—exactly on the hour—for our first session. When I introduced myself at the door to the waiting room, Marc was speechless and sullen. He walked past me through the hall, ricocheting off the walls. He seemed to be worried that he would come too close and touch me as he passed over the threshold. Eyes downcast, Marc sat in the chair across from mine, facing the couch, appearing quite depressed, emotionally beaten, battered and bruised by experience. I feared that he might be too sore to be touched.

Marc began by explaining that his former analyst's announcement of her intention to retire had precipitated his decision to end the analysis when he did. However he wanted me to know that he had terminated, not because his analyst was ending her career, but because he had become aware that the analysis itself had effectively come to an end many years ago.

Marc explained that he was married and that he and his wife had a new baby. He had begun dating his wife soon after ending a long relationship with another woman, which had been based upon and sustained by little more than an intense sexual attraction. He had not been attracted to his wife in the same way as he had been attracted to this woman, but had liked and admired her, feeling her to be a good person. He then said that although he loved his child, he thought that he should never have become a father. He often felt neglected by his wife and resented that there seemed to be no time for him to have a life—with or without her—since the birth of their baby. He added that, when his wife went out, he enjoyed the time alone with his child, although he resented that his wife seemed to be able to continue on with many of the activities she had engaged in before the baby's birth, while he, in contrast, felt stuck. Marc had not felt psychically alive for many years. He also experienced himself as a failure in his profession. He had often

considered having an affair with his former lover so that he might feel at least physically alive. However, he was afraid this would mean the end of his marriage.

The patient concluded his monologue, telling me that a friend who was a colleague of mine and who had been impressed after reading a book I had written had informed him about my work. However, he warned that he still did not have much faith in anyone being able to help him. He also mentioned that he did not like the idea that my husband shared my office suite.

Over time I said to Marc that I thought that he was telling me that, on one level, he could not feel any strong emotional attraction to me and did not really feel capable of fathering the baby—he. He was afraid to be stuck in yet another dead relationship, like his previous analysis or the way he currently experienced his marriage. However, he seemed also to be afraid that if he did come to feel alive with me, that it might lead to the end of his marriage. I added that he might also be fearful that, should he begin to feel strongly about me, he would be vulnerable and might suffer devastation on the weekends when I go off and am felt to betray him with another, depriving him of life (just as he feels betrayed by his wife when she goes off with his child, or in identification with his baby, when she goes off leaving them both alone).

Marc looked pained and said that he thought that this was true, after which the pained look turned to one of extreme disturbance and agitation and he hastily added that he had "been fooled before." There was a brief silence after which he said that he had been thinking of a story he'd read in the newspaper about a good Samaritan who'd been in the wrong place at the wrong time and had suffered a fractured skull at the hands of a madman. He said that when he'd read this story, he'd felt oddly guilty for what had happened. I felt here that I needed somehow to address Marc's painful disappointment in psychoanalysis and the rage that was secondary to this disappointment, palpably seething underneath the surface of every word he had uttered. I told him that I thought that he was letting me know how crushed he'd been by the realizations about his previous analysis that had failed to bring him to life after so many years, and that he was afraid that, although on the one hand he sensed my intentions to be benign, he was so sore and raw that my words had been felt as incredibly painful and maddening and that he, in turn, now wanted to break me, and was feeling guilty and ashamed about that.



Marc left that first hour seemingly relieved and asked to begin twice weekly meetings the following week. Subsequent hours were filled with material that revealed a preoccupation with the physical qualities of my office and of myself—particularly my “large breasts” and the way my room was decorated—and his fear that he would not know if I were the wrong analyst for him. Phone contacts—initiated by the patient in a panic between these sessions—lead me to convey to him my sense of a little-he who was sticking to me for dear life, and in so doing, had lost his capacity to distinguish between the way he experienced me and the way I experience myself. It also seemed that my body—my physical presence or perhaps my “body of work”—so impressed him that he was afraid that he was attracted to this, rather than anything inside my mind that he could perceive through the way in which I spoke to him. Regarding my room, we came to understand that he was worried that if I was coordinated and pulled together thoughtfully, that I could not understand or might be put off by a little-he who was disorganized and in pieces and all over the place much of the time.

In one hour, Marc said he was not sure that he could see any difference between his former analyst and me and confessed that he was “always looking.” I said that I thought that he felt he must keep an eye on me, to be sure I was not his former analyst. He laughed and said that he had thought, as I said this, that he did not wish to lie on the couch because he might forget who he is and get lost in a deep regression in yet another bad analysis. He added that he felt always “stuck up a horses ass, his head in shit.” I said that perhaps he felt stuck with his head in my book, and that he sensed this was the wrong place for him. Perhaps he feared that I would not be able to generate any new thoughts just for him and in response to him. He was worried that I might treat him “by the book” and felt that he had to stay vigilant and keep his guard up. In the next session to my surprise, Marc decided to lie down on the couch, and soon afterward asked to increase his hours to four times per week.

### Nell

Like Marc, Nell came in complaining of her former analyst’s behavior, which she described as “manipulative and intimidating” and which she had remarkably endured under constant protest for a dozen

years. She said that she thought that the analyst’s “religion” and hers could never be compatible. Then she reported a dream she had on the previous night:

She was at a party in a church and the people there were all in costume, like the masked ball in the *Phantom of the Opera*. They were not Catholics like herself, but actors. The Pope was there watching the people as they received the sacrament and took the Eucharist. Nell walked to the aisle to go up to receive the blessing and the Eucharist when she saw a man in a gold and diamond robe walking toward her. They walked up to the altar together. He looked like Christ but he was just an actor. Nell realized that he planned to desecrate God by taking the Eucharist away with him and not swallowing it and she cried out in an attempt to stop him.

Nell’s association to her dream was that her former analyst had tried to take away her faith and that, although she knew that I too was an analyst, she had only come for therapy and was only interested in coming once per week. Although I also recognized and kept in mind the many implications of this dream, perhaps forewarning of a part of Nell that might only appear to take in what I might give her, and in so doing would desecrate our work together, I chose to say that I thought the dream was communicating strongly how she had lost faith in analysis and suspected that I was no “savior.” I added that it seemed to me that she feared that not only would I be antagonistic toward her religion, but that analysis was merely an act of desecration against a personal God, perhaps some way of protecting and nourishing herself that she had organized throughout her life (Mitrani, 1996). She was fearful that I would not respect her or her means of surviving, but would merely use and exploit her for my own purposes, which were not her own.

Soon after this hour, Nell seemed to be able to let go of her preoccupation about her former analysis and took up a new process with me when she discovered that I might be capable of sufficient respect and adequate attention to all of her experiences and past discontents expressed in the present context of our relationship.

Such experiences, discussed in this chapter, have convinced me that careful analytic listening and consistent interpretation of the patient’s experience in the here-and-now of the hour, right from the beginning, can facilitate the emergence of the infantile transference and obviate the necessity for “educating the patient” about psychoanalysis.