Thinking and not being able to think

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Abstract

In this paper I draw on valuable perspectives from a range of psychoanalysts in the British psychoanalytic tradition to understand a particular transference-countertransference dynamic, namely one in which the therapist is rendered unable to think. I explore what makes the capacity to think possible and what gets in the way of thinking.

Whakarāpopotonga

I roto i tēnei tuhinga ka whakamahia e au ngā tirohanga marihi mai i ētahi whiringa kaitātaringa i roto i te tikanga mātanga hinengaro kia mōhio ai ki tētahi `whakawhitinga – whakawhitinga taupaepae hihiri, arā tērā ia e kore ai e taea e te kaitukuhaumanu te whai whakaaro. Ka tūhurahia e au he aha e taea ai te kaha ki te whai whakaaro ā, he aha ngā pōreareatanga o te whaiwhakaaro.

Key words: Bion; thinking; truth; hatred; 'facts of life'; confusion.

Introduction

This paper was inspired by the evocative title "Standing on the Shoulders of Giants", which Mark Davis offered in a presentation to the Wellington branch of the New Zealand Association of Psychotherapists (NZAP) in 2019. Since it was written Mark Davis, psychiatrist and therapist, has died and this paper recalls an esteemed and appreciated colleague and friend of many Wellington psychotherapists. In exploring the topic of "Thinking and Not Being Able to Think" I will be introducing some of the giants on whose shoulders I find myself standing.

My paper attempts to understand a recent failure in a therapy case. I realised, after my patient left, that I was not able to recognise a transference dynamic — that this patient wanted me to play masochist to his sadist. I could not see this dynamic clearly until he had left. I could not think clearly about what was happening in the transference relationship. I got lost.

I explore below how and why this might have happened. How it is that sometimes we can think about our patients, when there is space in the relationship to think, or space inside our

Hirschfeld, A. (2021). Thinking and not being able to think. *Ata: Journal of Psychotherapy Aotearoa New Zealand, 25*(1), 35–44. https://doi.org/10.9791/ajpanz.2021.04

minds, and how at other times it is very difficult to think, and we find ourselves confused, unengaged, unable or unwilling to understand. I begin by drawing on analytic theory to make sense of what makes the capacity to think possible, and how 'attacks on linking' make thinking more precarious. The theory I draw on is primarily from the Kleinian or post-Kleinian tradition. I will be referencing the following 'analytic giants': Betty Joseph, Wilfred Bion, Roger Money-Kyrle and John Steiner. I will also reference ideas from Donald Winnicott who worked in the Independent tradition[2].

I then provide two clinical examples (the first one being the 'failed' therapy I refer to above) to illustrate clinical encounters in which thinking becomes difficult for me. The first example reveals a dynamic in which the patient is critical, and the therapist feels criticised. This therapy ended prematurely, and the process of thinking was curtailed. The second example shows a patient who cannot work within the constraints of the usual therapeutic frame. I offer this second case to show how the therapist can, over time, regain the capacity to think and understand, when attacks on linking have made this process difficult. In both examples the therapist's ability to think creatively and clearly is blunted.

I want to leave some space for thinking in this paper, and hope not to stuff it so full that no space is left. Sometimes when a patient fills up the whole session with words it is hard to think, and it can be useful to say 'I think you are filling up the session because you don't want me to be able to think'.

Thinking — An Emotional Experience

In an interview called *Encounters through Generations*, made by the Institute of Psychoanalysis in 2010, Betty Joseph is asked about the qualities it takes to be an analyst. She says:

> I think the most important thing is to have a sense for the truth. To have a real sense for the truth in relation to yourself. And be prepared to know or to try to find out what's going on, and how things are hitting you. Because only that is going to enable you really to face what's going on in other people (0.36).

Betty Joseph was one of the leading Kleinian thinkers of her generation, who died in 2013 at the age of 96. She was influenced by Bion, and she was the analyst of John Steiner, a New Zealander and another of the giants I draw on in this paper. In this quote she is speaking about thinking and finding the truth when we are working. She made significant contributions to psychoanalysis on analytic technique, and her commitment to honesty, and truth, was a crucial part of her technique.

To lay some groundwork on this area of thinking and not being able to think, I want to begin with Bion, as he had a lot to say about thinking (see for example, Bion, 1962a, 1962b,

1 Anna Freud and Melanie Klein were unofficial rivals who generated protracted debates within the British Psychoanalytic Society between the followers of Klein and the followers of Freud. With the so-called 'controversial discussions', between 1942 and 1944 the British Psychoanalytical Society split into three separate training divisions: (1) Kleinian, (2) Freudian, and (3) Independent. The Independent Group (otherwise known as the Middle Group) of British analysts developed what is known as the British independent perspective, which argued that the primary motivation of the child is object-seeking rather than drive gratification. The Independent group is strongly associated with the concept of countertransference as well as with a seemingly pragmatic, anti-theoretical attitude to psychoanalysis.

1963, 1967/1988, and 1970). For Bion, thinking is primarily an emotional experience. He saw the capacity to think as the outcome of early emotional events between a mother and child. Knowledge of the psychological, he would say, precedes knowledge of the physical world, and he sees the first form of thinking as a baby striving to know another emotionally. Bion gave us the term "Maternal Reverie" (Bion, 1962a), a beautiful term which describes the capacity of the mother to love and think about her baby, allowing the baby gradually to internalise a parent who is able to think, and gradually to absorb the experience that feelings can be modified, understood and related to. Winnicott gave us another evocative phrase relevant to the early months of life, "Primary Maternal Pre-occupation" (Winnicott, 1958/75), the state of mind in which the new mother becomes biologically and psychologically conditioned for special orientation to the needs of her baby. He recognised that a lack of attuned pre-occupation in the post-partum period can lead to an experience of impingement which interrupts the "going on being" (Winnicott, 1960) of the baby.

As Bion saw it, thinking is originally based on projective identifications from the baby to the mother, which the mother successfully intuits and hands back, in modified form, to the baby. Bion expanded psychoanalytic understanding of projective identifications to include not only omnipotent projective identifications (the mechanism by which parts of the personality felt to be destructive are split off and projected into external objects) but also normal projective identifications, which are used by the baby to communicate.

This process, in which sense data/experience is converted into meaningful experience, is called the "alpha process" (Bion, 1962a). The mother's "reverie" is her alpha function, and represents her ability to modify her child's tensions and anxieties. The mother and the child form a "thinking couple" (Bion, 1962b) which is the prototype of the thinking process that continues developing throughout life.

When patients come to see us there is often the hope that the therapist's understanding will be transformative. This hope has its origins in some previous experience of having been understood. Where there has been a difficulty in the reciprocal flow of understanding between a baby and mother we meet a patient who conveys in words or actions a sense of hopelessness that their pain or frustration can be transformed or ameliorated by love, or by thought.

Bion referred to learning from experience as K. K emerges out of the link (originally) between mother and baby, from a successful container (mother)/contained (baby) relationship. Minus K (–K) is understanding denuded until only misunderstanding remains. There are many instances of minus K. One example of this would be psychosomatic symptoms. Another instance, which I am exploring in this paper, is when we have a patient and a therapist in the consulting room, and the therapist cannot think, and at times doesn't even want to think, about the patient.

Bion wrote the book *Learning from Experience* in 1962. At the same time as he was writing this book he was also, separately, writing about his experiences as a tank commander in World War One, completing the war diary that he had begun but never finished. Attempts to think, and write, about one set of experiences — traumatic, unbearable experiences in the war — informed his thoughts on the other — in this case, thoughts on the nature of thinking itself.

A fascinating paper by Lawrence Brown (2012) traces Bion's discovery of alpha function

and its subsequent elaboration. The paper describes how Bion's traumatic experiences as a young tank commander in World War One gave him first hand exposure to painful emotions that tested his capacity to manage, and also tested his capacity to think. The paper describes how he was completing the writing of his war diaries at the same time as he was writing his seminal book *Learning from Experience* (1962a) and how one piece of writing informed the other. As a consequence of his war experiences Bion had a profound respect for the difficulties in thinking while under pressure, and also had great respect for the power of containment as a prerequisite for the capacity to think, especially to think about feelings.

Bion was only able to begin to think about his experiences in the war and record them many years later when he was held inside a loving relationship — that of his second marriage. His first wife had died in childbirth, and he had raised his daughter, Parthenope, alone. He felt guilty about his first wife's death, as she had been reluctant to have a child and he had convinced her to do so. His next wife spoke early on in their relationship of her idea for a nursery, and her engagement with and enthusiasm for having a child allowed hope and faith to re-emerge for Bion. Inside the comfort of this loving relationship and satisfying marriage he began to recover, he began to be able to think again. He developed the idea of containment — that of the container and the contained — and how being contained allows for thinking to take place, and from there to being able to Learn from Experience.

In his paper "Attacks on Linking" (1959), Bion explores destructive attacks which he observed patients making on anything which is felt to have the function of linking one object with another. The prototype he suggests for all later links is the primitive breast or penis. In the therapeutic situation where the therapist has a wish to establish a link with the patient we have a more sophisticated version of this, and our patients' attitude towards this link gives us a way of observing his or her disposition towards links in a more general sense.

Now I will refer to some clinical examples to illustrate these ideas. The first example is the 'failed' case which I refer to at the start of the paper.

Clinical Example 1

As described already, this is a patient whom I could not think clearly about while I was working with him, but could begin to make sense of only after he had left. He left, prematurely, because I made a mistake. I double booked an appointment and had to send him away, and after this he terminated the therapy. Why did I make this mistake? It was unintentional, unconscious. The double booking had to do with the state of confusion, and un-thinking, in which I found myself.

I would like to describe some of the conditions which I feel contributed to my not being able to think with this patient. One of these conditions was that I was set off balance by regular and sustained criticism. This was initially of my environment — the path to my house was overgrown, the access to my garage was compromised, the placement of rubbish bins in the garage was obstructive, my toilet seat had a loose hinge — as well as criticism not only of my environment, but also of my thinking; there was the suggestion that I didn't really know what I was talking about, or what I was doing, and that some of the things I was saying, especially Oedipal interpretations I made (for example that he was curious about what went on in the rest of the house in which I worked, and particularly who might live there with me), were "very strange". There was the assertion that I was a "thinking type" not

a "feeling type" and that, as such, I was rigid and analytic, and so the therapy could not reach the places it needed to. Any suggestion I made that there was a relationship of any significance was met with derision. Any suggestion I made that breaks in the therapy had significance were strenuously denied. There was a subtle and sometimes not so subtle tone of mocking and denigration.

Three factors Bion (1962a) identified are L (Love), H (Hate) and K (Knowledge), along with minus L (-L), minus H (-H), and minus K (-K). These stand for the predominant links the patient establishes in the hour with the therapist. Bion saw any human as endlessly involved in establishing a link with another, but the linking might be loving, it might be knowledge-seeking, it might be attacking or destructive.

The criticisms I have described contributed to the overall link in the session (in other words, the transference relationship) becoming destructive. In particular this critical transference dynamic made it hard for me to think.

Psychoanalytic psychotherapy is a process which aims to achieve psychic change through understanding. One of the basic links that connects patient and therapist occurs in that a patient comes to us seeking understanding, sometimes to understand themselves, and if this is not possible, at least to be understood by someone else. It is interesting to note that this patient, though he claimed to want to gain insight and understanding in some realms, also let me know that he had met me many years previously and found me attractive, and was in fact coming to therapy for "fun". As such, this was a different than usual link between patient and therapist, and also may have contributed to some of the difficulties in my thinking. Though he called the object of his therapy "fun", I think what he meant by fun was, in fact, sex, and sport. Maybe if he got sex he'd have been happy, and wouldn't need to have sport with me, but in the absence of sex, he'd get the better of me with sport. In any case, this isn't typically what's on offer in therapy.

Clinical Example 2

I have seen a man for several years in my practice who in the first stage of his therapy repeatedly attacked the link between us in the most overt of ways — by not showing up to his sessions or by being late to his sessions, and by not paying his bill. Also, in less overt ways, his material was very hard for me to think about or connect to. I often had no real idea what the relevance was to his life, his therapy or to us as a pair, regarding what he spoke to me about. He referred to numerous other people, an ever-changing cast of relatives and friends, of whom he spoke appreciatively, and often in great detail, describing their family structures, life experiences, and sorrows, all in a manner with which it was difficult to make connections. Unlike with other patients, these people he spoke of did not feel like parts of himself, nor could I easily ask (as I might with another patient) "Does that remind you of anyone else you have known?" This was more like watching a soap opera and having no sense of who the characters were nor any hope of getting to know them. He seemed to not want me to say anything, and waved his hands at me if I did speak, a gesture to silence me, yet expressed gratitude and appreciation at the end of each session, assuring me that therapy was enormously beneficial and "really working". He sometimes rushed at me to hug me at the end of the session, as he expressed his gratitude. He lived out of town, so many sessions were by phone and he occasionally came to Wellington.

A regular pattern emerged in that, before his appointment, he would text me that he was about to phone me "in five minutes" but the words in his texts never matched what happened; five minutes meant ten, or 15, or 20 minutes, or half an hour. Once, whilst in Wellington, he texted me that he was on his way to his session, and over the next hour sent five or six texts saying "almost there". He arrived at exactly the end of the hour, at which point I had to send him away. He was very disappointed. On other occasions he seemed to be testing me; once he sent a text saying "will call in five" only to show up at my door in person, with a mischievous glint in his eye, as though checking to see if I was really in my room as I was supposed to be. My trustworthiness was at stake, as was his. These were all attacks on the linking function of the boundary of the session, and of course needed interpreting. Sometimes I would make interpretations, but at other times I wouldn't, or couldn't, as my mind had been so effectively numbed and wiped out by these attacks on linking. A degree of hatred was provoked by this, of course.

In his paper "Hate in the Countertransference" (1949) Winnicott writes about the difficulty of working with patients with psychosis. He describes how in working with people with psychosis there is likely to be a countertransference response of both hate and fear. He writes "Analysis of psychotics becomes impossible unless the analyst's own hate is extremely well sorted out and conscious" (p. 69). He goes on to say "that in certain stages of certain analyses the analyst's hate is actually sought by the patient, and what is then needed is hate that is objective. If the patient seeks objective or justified hate he must be able to reach it, else he cannot feel he can reach objective love" (p. 72).

So, a few thoughts on conditions in which it is hard to think:

- It is hard to think when you are under pressure;
- It is hard to think when you are being criticised;
- It is hard to think when you are feeling angry/hateful;
- It is hard to think when you don't feel loved.

This second patient's mother was a beautiful model who did not show love or empathy for her children. The reports we hear of mothers are of course always subjective accounts, but I came to recognise in the transference relationship that this appeared to be an accurate report of a very faulty bond.

Over time I came to interpret that he wanted to come to the session to meet a father-me, and that he also didn't want to come to the session to meet a mother-me, and that these two impulses were in conflict, so he both wanted to come and didn't want to come to his sessions with me. I might have interpreted this ambivalence in any number of ways, but this simple explanation was part of beginning to speak a simple language with someone who was very confused. I also said that I thought that it was a little him who was coming to give me a hug, as a child would. As an aside, he hugged me, not the other way around. Charlotte Dallenbach told me (personal communication, June, 2018) that when hugging patients, it is important that the therapist does the hugging. I used this piece of information and one day when my patient approached me to hug me, I told him that he wasn't allowed to hug me today and that today I was going to hug him, and I did.

These seemingly simple understandings took a long time to reach. I think this is

because the attack on my capacity to think was so strong. Being with this patient who regularly cancelled or was late, and payed reluctantly, provoked in me at times a great resistance to wanting to think about him, and in this way, he press-ganged me into being like his mother.

Though I have suggested that it is hard to think when you do not feel loved, Bion introduced the fundamentally important idea that thinking emerges not in the moment of direct contact between the baby and the breast, but in the space created when the mother is absent — when the baby must begin to think about where the breast, where the mother has gone. That is why it is important for mothers to be good enough, but not too good — it is in the places where there are gaps that thinking begins.

Clinical Example 1 — Further Thoughts

It was only after he left that I had a breakthrough in my understanding of what had been happening in the transference relationship with the critical patient. With some distance I was able to see that this patient had been gradually creating a dynamic where I would play masochist to his sadist, and he was tiptoeing towards this via the constant critical attacks he made on me.

His criticisms of a troublesome or insufficient environment acted as a superego projection which hooked on to my own insecurities about my home and environment, and I began to feel very concerned about the overgrown ferns on my path, or temperature fluctuations in my consulting room, or the hinge on my toilet seat. I began to feel that I needed to change and improve things.

I was beginning to adopt a masochistic position of self-criticism and submission. My patient had ejected an unbearable experience of his own in a sadistic way and was creating a situation in which it appeared that I needed to change, rather than him having to work to change himself. Had the therapy continued I would have had to contain, understand and also transform this expelled experience, and help this patient dis-identify with his need to be in control and perfect at all times.

These realisations led me to have further valuable thoughts regarding what I was meant to be doing as a therapist and what I wasn't meant to be doing. I realised I did not need to have a perfect room or offer perfect interpretations. What I did need was to be able to maintain the conditions which were needed for thinking 'under fire'; the state of mind which allows us to be receptive and involved (empathically attuned to the patient's reality) and then distant and separate (understanding that reality from a separate position).

Throughout this paper I have been examining conditions in which it is possible to think and also various climates which are created in which thinking becomes very difficult. This raises the question — what might help when this happens? When we recognise that thinking has become difficult? I think that in these situations it can be tempting to either *do* things (as I said, I began to feel that I needed to improve my room) or alternately to switch off, become passive, or helpless. What helps? I think what we have to do is to keep listening, and to resist acting, to try to make space for some understanding of what is going on.

Here is John Steiner (Institute of Psychoanalysis, 2015) describing what I think of as a particularly analytic stance in which he highlights the importance of listening and the importance of limiting our actions. He is speaking about Ulysses and the Sirens:

> The Sirens seduce you with their music and the danger is you leap into the sea and get devoured by them. But Ulysses wanted to hear this music. So, what he did was put wax in the ears of the rowers so they wouldn't stop rowing. He tied himself to the mast so that he couldn't jump overboard. I say to people, "Tie yourself to the analytic chair and remember you're an analyst and you're not the patient, and you're not with the patient. You're trying to understand the patient. So, you let the projections come in but you say 'no way am I leaping in to this' (2.06).

Before I finish I want to introduce one more giant: Roger Money-Kyrle, another Kleinian. Money-Kyrle (1971) proposed that all adult thinking is hampered by the difficulties surrounding three aspects of reality. He called these realities "facts of life". He wrote that these "facts of life" are aspects of reality which are particularly difficult for us to accept, but an inability to come to terms with them leads to a generalised problem with other aspects of reality, or even to a (conscious or unconscious) delusional relationship with reality. Powerful defences are mounted against recognition of these facts. His three primal facts of life are:

1. The recognition of the breast as a supremely good object;
2. The recognition of the parent's intercourse as a supremely creative act;
3. The recognition of the inevitability of time and ultimately death (Money-Kyrle, 1971, pp. 103–106).

I want to look at the first of these "facts" in this paper. The "recognition of the breast as a supremely good object" was Money-Kyrle's evocative way of describing the reality that as infants we are utterly dependent on things and people external to us. The source of goodness we need for survival, and for emotional well-being, lies beyond our control. With this "fact of life" come all the problems of dependence — initially the infant's gradual recognition of their dependence on the mother.

In the first months of life this troubling reality is made manageable by splitting between good and bad experiences. Gradually there is an integration of the good and bad aspects of the breast, and increasing recognition of the separateness of self and object.

When this cannot be tolerated a narcissistic defence develops. The narcissistic defence deals with the problem of dependence, and the powerlessness that comes with it, by taking over the breast and evading any experience of separateness.

In the first case example I have written about in this paper this "fact of life" is evaded by denigration of the therapist/breast. The therapist is deemed to have no value, and can be criticised and controlled. Separateness is therefore not a problem — if it's no good really, you don't have to miss it. This is what is referred to as the manic defence — a triumvirate of control, contempt and triumph.

In the second example the therapist is not denigrated, seemingly. The therapist is described as having enormous value in the session. But behind the scenes we see other messages — the lateness and the non-payment show that the therapist is not valued, so there is a splitting that occurs in that all good aspects are allowed into the room, and all bad aspects of the therapist are kept out.

In both cases — the valuable therapist who is separate is denied, and depressive awareness

of separateness — dependence and loss are avoided. In both cases, hatred is provoked in the therapist. In both cases attacks are made on linking.

Conclusion

Betty Joseph said that the most important quality it takes to be a good psychoanalyst is "to have a real sense for the truth in relation to yourself." (Institute of Psychoanalysis, 2010, 36 secs.) I think this makes intuitive sense to us all as therapists. But getting hold of the truth is a tricky business. When we get hold of it, we feel it in our therapy bones somehow, something clicks, or makes sense finally, and we have a moment of freedom. But these moments are elusive, and we position and re-position ourselves to try to make ourselves available for them. At other times we lose this positioning entirely and become confused or unthinking, blind, bored or bland with our patients.

In this paper I try to make sense of both the experience of finding the truth in relation to ourselves and of what might be happening when we lose access to this truth and lose touch with ourselves. I give two case examples in which thinking clearly is very difficult. The first example is a case where the therapy ends prematurely and the sadist-masochist dynamic is not recognised or able to be worked through. The second example shows how the therapist regains a capacity to think.

I describe Bion's profound contributions to the way the capacity to think develops. Both Bion and Winnicott clearly put a mother's pre-occupation with her baby as central and vital for the development of the ability to think, and especially to think about feelings. Bion also described how in the absence of containment it becomes almost impossible to think.

We know that we need containers and containment in order to think. We find containment in our experience of individual therapy, in our supervisory, collegial and personal relationships, in groups we belong to and also in the theories which underpin all of our clinical understanding. I have drawn on perspectives from analytic giants in this paper, perspectives I suggest we can all draw upon when we are assailed with states of confusion or un-thinking.

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