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Missing the Analytic Connection: Some Perils of Therapeutic Ambition

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> Under present-day conditions the feeling that is most dangerous to a psychoanalyst is the therapeutic ambition to achieve by this novel and much disputed method something that will produce a convincing effect upon other people. This will not only put him into a state of mind which is unfavourable for his work, but will make him helpless against certain resistances of the patient, whose recovery, as we know, primarily depends on the interplay of forces in him.
>
> (Freud, 1912, p. 115)

Note: In the interest of confidentiality, all case material has been disguised or fictionalized. It is constructed of composites of several patients and multiple real-life scenarios with details altered to ensure anonymity. Any similarity to real persons, living or dead, is coincidental.

Introduction

A cartoon depicts a patient lying on the analytic couch, looking dismayed and disbelieving, as his analyst is storming out of the office with an expression of extreme disgust and exasperation. The analyst's pen and notebook are strewn on the floor, in front of the chair he has vacated. The analyst is exclaiming as he leaves, "This isn't doing **me** any good!" (Goldberg, 2013).

In this paper, I would like to discuss certain conscious and unconscious countertransference dynamics as we attempt to sustain an analytic frame of mind in our work. Specifically, I would like to explore the nature of the relational connection we desire as analysts, and the emotional turbulence that arises when our patients do not provide this connection for us in the way we wish. My reflections began to crystallize when discussing a presentation by Otto Kernberg (Rather, 2013) in which he focused on

the pathological narcissism of patients who ignore, devalue, and dismiss their therapists as a matter of course (see also Kernberg 1975, 1984). I was struck that the usual focus tends to be on the patient's psychodynamics, and therefore would like to focus on some common reactions of therapists on the receiving end of such dynamics.

As an analyst, a case consultant, and as a case conference leader, I have noticed that the experience of working with patients who do not exhibit a sense of being connected to us or having feelings of being shut out by a patient are among the most difficult states for therapists as a group to tolerate and process. Why do such patients stir up such negative countertransference and frustration? Why is this sort of patient so often the *bête noire* of otherwise excellent clinicians?

The word "missing", in my title *Missing the Analytic Connection*, is meant to imply two different but closely related themes: first, that the analyst misses, in the sense of *longing for* a type of connection that *isn't* there and secondly, that the analyst who is overly disturbed by this is at risk of missing, in the sense of *overlooking* the connection that actually *is* there. From the point of view assumed in this paper, each of our patients is inevitably connected to us, and even the patient who appears 'disconnected' is connected to us, for example by having to keep us at a distance. This could be thought of as the 'non-connecting transference', or perhaps better yet, the 'apparently non-connecting transference'. In discussing this, I am using the terms "analyst", "analysis," "therapist," and "therapy" somewhat interchangeably to refer to anyone attempting to work analytically. I also acknowledge that I'll be making broad generalizations about therapists as a group and recognize that these may not apply in all cases.

Clinical Vignette 1

It is the end of the last session of the week. Mr. R pauses at the door. He is a tall man, perfectly groomed, and as usual, dressed elegantly in one of his many beautiful black suits. With an air of *noblesse oblige*, he turns to me and says in a mock patrician accent: "Have no fear. I shall be back on Monday to share more of my insights and theories". The fact that we are both able to chuckle at this 'ritual' is the result of many years of work.

Mr. R had been pushed into treatment by the threat of divorce and the failure of a recent entrepreneurial voyage during which his colleagues, nicknaming him 'Captain Bligh', had mutinied. Although he came to take pleasure in his sessions as an opportunity to talk about himself to someone who listened closely, he conveyed a sense that he failed to see what I could offer and responded to interpretations, especially transference interpretations, as if I had stepped into his movie and was trying to steal the scene. Over a long period in our work, I had to endure, contain, and work-through intense countertransference reactions of boredom, hatred, futility, smallness, wounded professional pride, and the like, as I was lectured, critiqued, and condescended to when he paused long enough to actually listen to me. During this time, I was at first only able to frame what was happening as some sort of destructive process on his part, but all interpretations in that direction proved useless, sometimes increasing my sense of futility in my own desire to feel more connected and valued.

He dismissed exploration of his dream life as a remnant of a lapsed Victorian science that, though charming in a sort of literary way, was essentially 'antique'. But sometimes

he humored me by recounting what he called his 'nighttime misadventures', and after several years a dream marked the aggregation of many small moments of work into a turning point.

> *He dreamed that he was in a house at the very top of a hill, in his bedroom dreaming, and, in the dream, became gradually aware that a group of aliens had regularly abducted him throughout his life. This time he could see them. They were figures in black suits, and though he was frozen on his bed, he could hear their strange and seductive voices. At some point he sat up and said, "I've had enough, now get out of here". He grabbed the arm of one of the aliens and was extremely disturbed that it was not the cold black carbon fiber he had expected, but was instead a very soft, warm, and human flesh. At this point, the alien 'shape-shifted' into a Fairy Queen, who took him in for protection and began leading him down the hill, through the garden on a confusing path.*

As the furniture in my office is black, and Mr. R is almost always dressed in black clothing, the dream suggested to me what Rosenfeld (1987) has depicted as an internal object "gang" of aliens fighting dependency with a barrage of internal propaganda and fear mongering. 'Being frozen on the bed' vividly portrays both the unconscious anxiety and the paralyzed progress on the analytic couch which results from this unconscious resistance. In Mr. R's associations, he recalled that having dismissed his parents, he read himself bedtime stories in which children wandering lost in a forest would become enchanted by a fairy, taken into a wonderful new world, only to be abandoned when the fairies tired of them. "Fairies," he also told me, were what they called the weaker men in

the rugged hill country of his youth, before he came to “airy-fairy California, the land of therapy magic.” He played with the phrase “taken in” and its double meaning and wondered whether I was “leading him down the garden path”. Was I a weak Fairy Queen, a benign Fairy Queen, or a Trickster Fairy Queen? Was I one of the aliens or an ally against the aliens? Was he an autochthonous child (Grotstein, 2007, p.144) who thought he had self-sufficiently raised himself, or a lost child fearful of being “taken in” in both senses of the term?

Without going further into the many intricate details of our work, this dream opened a metaphoric path for more deeply exploring the nature of our “unconnected” connection. Most importantly, to the theme of this paper, this beautiful dream work portrayed my patient’s internal landscape in such a way as to evoke new empathy and understanding in me, which had been blocked earlier by my negative reactions to his failure to connect with me and our work in the way that I wanted. My patient still bore a strong resemblance to Narcissus at the pond, but, because of my own need for him to gaze more at me and less at himself, I had been blinded. I had missed the fact that he was not so much enchanted by his own reflection as he was taking shelter by the pond to avoid the dangers of dependency represented by the “aliens” and “fairies” who he experienced simultaneously as unconsciously alluring. I could begin to see and accept that my patient’s “non-connecting” way of relating was primarily protective rather than destructive.

It is difficult to convey the visceral impact such changes in perspective have had on my work over recent years, but they have been transformative, leading to a steady

evolution in my clinical sensibility and interpretive approach. The term "psychopathology" has become, for me at least, much less useful as a concept dialectically positioned to "mental health" and in need of confrontation, interpretation, and treatment. It has become much more useful as a concept connoting the need for empathic understanding of the psychological suffering that leads us to twisting ourselves into overly rigid symptoms, defenses, and character organization. (Psychopathology is a term derived from the Greek roots psych, meaning "mind" or "soul", path, meaning "feeling" or "suffering", and ology meaning "the study of.") I try always to intuit and sympathetically interpret the psychic reality within which my patients' emotional attitudes and actual behaviors make absolute and total emotional sense. Said concisely, "The patient is always right," and it is our challenge to interpret how and why, given their current modes of titrating psychic pain, that this is the case (see Grotstein, 1990; Rather, 2015 for further discussion). With respect to the interpersonal connection under discussion, what this has meant for me is attending to the connection that is there, rather than desiring or pushing too strongly for the connection I might wish for.

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What Does the Analyst Want?

Who becomes an analyst? For most of us, being an analyst is not just a profession; it is a 'vocation'. This term, from the Latin root for being summoned or called, was once reserved for those called by God to the priesthood, but it has come to mean anyone who driven toward a profession by a deep sense of personal purpose. Most of us have been 'called' to this profession. We have trained long, hard, and at great expense, and in the recent era not so much for financial or social rewards as for seeking to fulfill our personal potential and destiny.

What does the analyst want? Generally speaking, as analysts we are hoping to work with patients who are able to form trusting relationships with us, who are able to gradually turn inward to explore themselves in relationship with us, and who are increasingly able to risk discovering and sharing with us more and more of their most intimate emotional experience, both inside and outside of the transference relationship. In this vision, our ideal patient demonstrates psychological mindedness, respects the analytic process, works well with our interpretive efforts, and, most of all, shows signs of appreciation.

When this vision materializes, we feel good about ourselves, competent and involved in a connected interpersonal relationship of the type that we want. As the adage goes, "Find work you love, and you'll never have to work again". But doing "analytic work" is often just that, "work," emotional work. I am referring to those other situations in which the patient does not seem so interested in the psychoanalytic project, or actively opposes it, or demeans the analyst. This may occur for shorter or longer periods with some patients, or it may also be a chronic and dominant feature with others. But, all it takes is for the work to cross a certain threshold of apparent non-connectedness, a little different for each of us, and, finding ourselves missing what we are seeking, we fall back upon the usual suspects: non-analyzability, aggression, acting out, distancing, destruction of the frame, perversion, resistance, repetition compulsion, impasse, psychic retreat, the death instinct, and so on. Sometimes we may be right, but not as often as we are tempted to think. Sometimes we may be as much in the grip of our own demons as we are in those of the patient.

Transferences We Love and Transference We Hate.

Psychoanalysis begins with Anna O. (Freud & Breuer, 1895/1955) and the erotic transference. While Breuer dropped the key, Freud, in a stroke of brilliance, picked it up by realizing that the erotic transference, and more broadly, the "transference neuroses" were not an obstacle on the path, but the path itself. Nowadays, even Freud's early conclusion that the "narcissistic neuroses" were untreatable has been replaced by a sophisticated set of theories and techniques for working with fragmented and psychotic transferences.

The erotic transference is difficult in its way, but with its long and honorable tradition, it tends to be more welcomed, at least by the analyst. In the erotic transference, at the very least, the analyst does have the patient's attention! Similarly, the so-called borderline's emotional rollercoaster of devaluation and idealization also places the analyst at the center of the patient's attention. Borderline idealization and erotic idealization may sometimes rub us the right way, but the "non-connecting" transference always rubs us the wrong way. The problem with Narcissus is not simply that he is captivated by his own reflection but, also, that the enthrallment with his own image is sustained by forcefully relegating the analyst to a seemingly extraneous role. In this way, the narcissist and his other "non-connected" brethren get right under our collective skin, hitting us right where we live in our professional and personal desire to feel helpful, valued, and loved.

Though the "non-connecting" patient comes in many flavors, charismatic, threatening, aggravating, or boring, the common ingredients are stirred together to serve up a patient who proceeds too much as if we weren't there. In cases of what Bion called "reversible perspective" (1962, 1963, 1965, 1970), this may not be simply a side effect of psychic retreat, but rather the main unconscious point:

> The reversible perspective consists, by definition, in that the subject begins analysis not in order to know himself, to be cured, to grow, or to resolve his problems, but with a different idea, which can even be to show his analyst that he does not need analysis. (Etchegoyan, 1991, p. 769)

Why does this rub us so much the wrong way? After all, speaking compassionately and depending on your theoretical perspective, the unfortunate "non-connecting" patient has been reduced to omnipotence as a solution to the problem of early trauma and/or the (m)other's uneven responsiveness, and has not yet traversed the difficult developmental ground of accepting dependence and otherness, a lifelong process for all of us.

Meanwhile, the analyst struggles to exist as a meaningful separate object with something to offer. We don't like this, and it most certainly does not fit our ideals. Bion uses the terms "narcissism" and "socialism" to differentiate the egocentric impulse from the socio-centric impulse (1992, p. 122). It is characteristic of therapists to highly value relationship, connectedness, empathy, attunement, the working alliance, and so on. Perhaps for us as a group, these constitute almost a form of mental health morality, one that is opposed by the narcissist's psychic ideology. While we stand for embracing

civilization with its discontents, the narcissist lobbies for an internal utopia where the discontents of difference have been made to disappear.

Clinical Vignette 2

I turn now to a case presented to me in consultation. The therapist was a very seasoned, highly competent, and compassionate person who was having difficulty with his patient, a young female attorney who, though paying for several sessions a week, was missing many of them and arriving late for those she did attend. The therapist could tolerate that the patient was under severe pressure by her firm, was often given work at the last minute, and wasn't always in a position to put her therapy first. That the therapist could more or less accept. What was getting under the therapist's skin was that the patient would usually "not bother" to call to cancel. Or when she would occasionally call, she would matter-of-factly state that she needed to get some work done or needed to go to dinner or perhaps spend some quality time with her fiancé. Furthermore, the therapist was flummoxed that on those times when the patient did cancel ahead of time, she never once asked whether it might be possible to reschedule her appointment.

The therapist felt dismissed, insulted, marginalized, angry, and, with the analytic police hot on his tail, worried that this wasn't "real" analytic work. Being keenly attuned to the notion of countertransference as a clue to the patient's internal life and because he felt so brushed aside, he inferred that this must signify a hostile transference, or a destructive intent toward the treatment. He recounted how this seemed to characterize other parts of his patient's life as well. For example, at one point in the therapy, the patient had landed an excellent new position, but was unable to complete some necessary

procedures to get a security clearance by the first of the month when she was to start. She had called her new employer and simply said she would be unable to fill the position, providing no explanation. The new employer was furious and wrote a scathing letter about how she had wasted his time and was thoroughly unprofessional. The patient's apparent inability to understand what all the fuss was about was perplexing to the therapist who now worried that his patient might be situated on the autistic spectrum. Why hadn't she explained; why hadn't she apologized? Why hadn't she negotiated for more time? Why hadn't she asked for help?

On the basis of his own feelings of hurt and identification with the new employer, now the therapist was sure there was a major destructive dynamic at work in the patient, though there was no supporting evidence in the clinical material. He was using his countertransference as a guide to what the patient's conscious or unconscious intention might be, and therefore it was natural to assume she must be acting in a hostile manner. And this very well might have been the case. But when the therapist feels slighted, this is one area where one must call countertransference feelings into question and not assume automatically that because you feel dismissed, that this is the intention of the patient! I asked the therapist to imaginatively consider whether he could dream up any other psychic realities in which it made complete sense that the patient's connection with him precluded her negotiating with others, asking for help, or trying to reschedule sessions. He decided that next time she cancelled a session he would ask why she hadn't asked if he had any other times.

This led to an important session in which he also asked his patient why she hadn't negotiated an extension from her new boss. She replied: "I just assumed it couldn't happen". This small comment slid right by the therapist, who, looking for evidence of a destructive instinct, missed what had just been placed in front of him, the "selected fact" (Bion 1962, p.72), the missing piece of the puzzle! As we examined the material and recent material more closely, it became clearer that the patient herself had virtually no "pre-conception" (Bion 1962, p.91) of an interested and concerned other with whom she could negotiate. Without such a pre-conception, she was limited to either resentfully complying with people or avoiding this by deflecting what they wanted. The latter had previously appeared passive-aggressive, but now we could see that the aggression was not the dominant part, the passivity was. It was not a matter of perverse destruction so much as a position of passive hopelessness.

The patient was also often oppositional regarding the bureaucracy and endless paperwork of her firm. Whereas this had previously seemed to the therapist to simply exemplify her self-centered narcissistic structure, he was now able to tie this together with the ongoing pressure for achievement that the patient had received from her mother all her life. From this new perspective, fighting with bureaucracy and paperwork could be understood as less about aggressive omnipotence and more about the deep wish for lost entitlement, a wish for the non-impinging holding environment that once might have been broader and deeper, but wasn't. We could now imagine her as an infant insisting that the environment stop impinging and demanding (Winnicott, 1948/1975a, p.157).

Regarding Winnicott, I also have noted that some therapists I have supervised have been disturbed that their patients sometimes seem to ignore an interpretation and then later on come back with it as if it were their own. To understand this, it is useful to keep in mind Winnicott's concept of the "period of hesitation" that he wrote of while discussing his "spatula" with infants (1941/1975b, p.53). Moved into the clinical setting, it means that the adult patient may not automatically respond in a conscious or communicative way to the analyst's interpretation but may need to "rediscover" it. Perhaps this is midway between the social and the private sphere…as if the patient were saying:" I need to consider your interpretation on my own time line, not necessarily on yours." In any case, what I have tried to convey in this vignette is that the countertransference to the apparent lack of connection clouded the therapist's vision and made it impossible to understand the type of connection that actually was there and to interpret it empathically.

Clinical Vignette 3

I turn now to another case presented to me in consultation again, by a very accomplished and sensitive clinician. The patient was a man in his late 20s who, despite high intelligence, had collapsed in college emotionally overwhelmed by the narcissistic challenges of being away from home and discovering that his peers were as intelligent and competitive as he was. He returned home, not with his tail between his legs, but on a cloud of contempt for the Ivy League. He took a job far beneath his intelligence but was soon fired for insubordination. By the time he came into therapy, he had fallen into a massive psychic retreat from life, secluded in his childhood bedroom, supported by his parents, and having as little to do with the world as he possibly could.

In therapy, he was cordial and talkative. His therapist found him quite likeable and felt a strong urge to make something happen by helping him get back out into the world "so he could have a life." What the therapist found most difficult was that he did not speak in the now culturally conventional, psychologically minded voice that she was expecting and hoping, the voice that would make her feel that they were connected and doing "good work". The problem for her was that he did not speak about his feelings and emotions, his conflicts and difficulties, or his failures directly. In fact, it had not ever been clarified between them why he wanted therapy in the first place. Nonetheless, he attended sessions regularly. The therapist felt her comments and questions were smoothed over and brushed away, and she felt excluded from his deeper emotional life. Although the patient gave no signs of dissatisfaction, the therapist consistently felt a sense of futility and disconnectedness because the patient didn't talk about anything that seemed meaningful and "psychological."

We came to understand there were two aspects to this situation. that we came to understand. First, through the process of projective identification, the patient had managed to make the therapist feel his own sense of helpless vulnerability and incompetence, emotional states that he himself was massively defended against feeling directly. Second, we came to see that the patient was *always* talking about his problems, but only presented them in derivative form, not in the psychologically minded speech that the therapist desired for a secure sense of connection.

There was a strong interaction between the therapist's frustration and her ability to listen to what the patient was saying in derivative form. Mostly he would talk about how crazy the world was: his mother was foolish in her emotions, his father involved in a career and personal pursuits that were absurd, politicians and policy makers were highly incompetent, relatives and online chat buddies were fools. While it felt to her that he was simply projecting, avoiding, and complaining, one could hear the truth in his complaints, and it was easy to formulate that, for reasons both of nature and nurture, he was telegraphing that he was unable to get his mind around and process the full impact of the difficult reality coming his way.

The therapist and I came to see that because she *missed* (longed for) the type of personal connection that she needed for gratification, she missed (overlooked) the latent content of his constant smoke signals, mistaking them for meaningless clouds floating by. She wished for him to talk to her more about his feelings like her ideal patient so that she could feel valued and connected and experience herself as a good therapist. This excellent therapist is not unusual in her desire, nor is the difficulty it creates in deeper analytic listening. Often, we are more comfortable with patients socialized to believe they are *supposed* to focus on and talk about their feelings and emotional dynamics in therapy, perhaps to the detriment of the analytic process. We need to bear in mind that Freud (1912/1958) stressed the importance of "free association" and viewing the content thereof as derivative material:

> It is wrong to set a patient tasks, such as collecting memories or thinking over some particular period of his life. On the contrary he has to learn above all-----what never comes easily to anyone--- that mental activities such as thinking something over or

> concentrating the attention, solve none of the riddles of a neurosis**;** that can only be done by patiently obeying the psycho-analytic rule, which enjoins the exclusion of all criticism of the unconscious or of its derivatives. One must be especially unyielding about obedience to that rule with patients who practise the art of sheering off into intellectual discussion during their treatment, who speculate a great deal and often very wisely about their condition and in that way avoid doing anything to overcome it. (p.119)

The Analyst's Neurosis and the Impossible Profession

At a recent meeting of the American Psychoanalytic Association, the plenary address was entitled "The Analyst's Narcissism" (Chused, 2012). Again, who is it that becomes an analyst? Our friends in other professions sometimes ask: "How can you listen to everyone's problems all day?" Despite the comic retort, "Who listens?" we do indeed listen with great emotional investment. Racker suggested that we become analysts in order to overcome our guilt, by repairing the objects that we feel we have damaged in the first place (Racker, 1957, p. 325). I can't say with certainty to what degree this is universally true or complete, but to the extent that it is the case, it implies a shared fundamental professional countertransference vulnerability and, perhaps, even a fundamental neurosis. Our characters and our defensive organizations will involve some variation of a grandiose professional self (Brightman, 1984), and we may be overinvested in ideals of omnipotence, omniscience, and benevolence that we wish our patients to confirm and validate. The "apparently non-connecting" or, more accurately, "differently connected" patient does not offer that and we can begin to feel somewhat persecuted. Here is another relevant quote from Racker (1988):

> …[A]n analyst may come to hate a patient who is in intense resistance. For this resistance sometimes leads to the analyst's being persecuted by his own superego; he defends himself against this persecution by means of projection of the bad introjected objects in the ego and simultaneous identification with the superego projected upon the patient, which, in turn, leads to his feeling hatred and becoming angry. (p.121)

Regarding connectedness, Winnicott (1965) also reminds us of the patient's legitimate need for privacy and non-connectedness.

> Although healthy persons communicate and enjoy communicating, the other fact is equally true, that each individual is an isolate, permanently non-communicating, permanently unknown, in fact, unfound…At the centre of each human being is an incommunicado element, and this is sacred and worthy of preservation. (p. 187)

Concluding Comments

Comparing his early professional ideals with the sum of his experiences at the end of a long career, Freud (1937/1964) concluded that psychoanalysis was the third of the "impossible" professions (the other two being raising children and governing nations). Years later, Bion spoke of "making the best of a bad job" (1994). It is clear enough how difficult it is to help our patients (and ourselves as patients) to deeply understand, contain, and face our psychological demons, and it is clear that analysis is fated to be

"incomplete". But on another level, as I have tried to illustrate, psychoanalysis is also an 'impossible' profession because the unconscious desires that draw us into becoming analysts in the first place are, by their nature, impossible to fully satisfy. As I have shown in this paper, this is especially the case with those patients who are seduced and reduced by the siren's call of omnipotence when faced with the storms of basic dependence.

It is possible that the shift from a one-person to a two-person psychology, and the overall influence of the "relational turn" and its emphasis on mutuality (Mitchell, 1988; Aron, 1996) has led to a stronger humanistic "I-Thou" (Buber, 1937/1970) vision of the analytic relationship. Papers presented at scientific meetings in my geographical area of the psychoanalytic world more frequently contain accounts of the analyst's personal emotional experience in clinical work, not just as informational countertransference but almost as autobiographical accounts of the rewards or frustrations of analytic work. If this impression has any merit in detecting a changing set of personal expectations we collectively bring to our work, we may need to temper our desires and expectations in order to draw upon a greater internal balance between maternal and paternal function (Bollas, 1999; Rather, 2008) or, put differently, between the frame of weaning and the frame of lost entitlement (Grotstein 1990). What these authors have pointed to is the need for the analyst to create an optimal mix of empathy and challenge that truly accepts our patients exactly as they are while simultaneously providing a space in which psychological evolution is potentiated. With the "non-connected" patients described in this paper, we must allow the patient to connect to us in his or her own way, accepting it rather than "opposing" it, while also interpreting its function, benefits and problematic side effects. In short, we are called upon not only to be empathic but also sympathetic to the human condition.

In discussing the optimal analytic attitude, Etchegoyan (1991) writes: “If an analyst lacks objectivity or goodness, or even pity for the defects of man… he cannot be an analyst” (p. 602). In a similar vein, Grotstein (1990) urges us to set aside emotionally loaded concepts of mental health and pathology regardless of how aggressive, resistant, perverse, or destructive the patient might appear to be. In this sensibility, the patient is always “right” and the work of the analyst is to discover and interpret the anxious psychic reality in which the connection is hidden. To return to the beginning, if we can achieve this, we might better tolerate *missing the analytic connection* in the sense of desiring something different from our patients, without *missing the analytic connection* in the sense of overlooking the complex transferences that are the heart of our work.

REFERENCES

Aron, L. (1996). *A meeting of the minds: Mutuality in psychoanalysis*. Hillsdale, NJ: The Analytic Press.

Abraham, N. & Torok, M. (1975/1994). "The lost object—me": Notes on endocryptic identification. In *The shell and the kernel: Renewals of psychoanalysis, Vol 1*, pp.139-164. (Nicholas T. Rand, Trans.). Chicago: University of Chicago Press.

Bion, W. R. (1962/1977). *Learning from experience*. In *Seven servants*. New York: Jason Aronson.

Bion, W. R. (1963/1977). *Elements of psychoanalysis*. In *Seven servants*. New York: Jason Aronson.

Bion, W. R. (1965/1977). *Transformations*. In *Seven servants*. New York: Jason Aronson.

Bion, W. R. (1970/1977). *Attention and interpretation*. In *Seven servants*. New York: Jason Aronson.

Bion, W. R. (1992). *Cogitations*. Francesca Bion (Ed). London: Karnac Books.

Bion, W. R. (1979/1994). Making the best of a bad job. In *Clinical seminars and other works*. London: Karnac.

Bollas, C. (1999). Figures and their functions. In *The mystery of things*, pp. 35-46. New York: Routledge.

Brightman, B.K. (1984). Narcissistic issues in the training experience of the psychotherapist. *International Journal of Psychoanalytic Psychotherapy 10*, 293-317.

Buber, M. (1937/1970). *I and Thou.* (W. Kaufmann, Trans.). New York: Charles Schribner's Sons.

Chused, J.F. (2012). The analyst's narcissism. *Journal of the American Psychoanalytic Association, 60*, 899-915.

Etchegoyan, H.R. (1991). *The fundamentals of psychoanalytic technique.* New York: Karnac Books.

Freud, S. & Breuer, J. (1895/1955). Studies in hysteria. *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 2, pp. 1-306). London: The Hogarth Press.

Freud, S. (1912/1958). Recommendations to physicians practising psycho-analysis. *The standard edition of the complete psychological works of Sigmund Freud* (Vol.

12, pp. 109-120). London: The Hogarth Press.

Freud, S. (1937/1964). Analysis terminable and interminable. *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 23, pp. 209-253). London: The Hogarth Press.

Goldberg, S. (2013, November). *Discussion of Lee Rather's paper, 'One Hand Clapping'.* Paper presented at Scientific Meeting of the Psychoanalytic Institute of Northern California. San Francisco, CA

Grotstein, J.S. (1990). The mirror and the frame. *Society for Psychoanalytic Psychotherapy Bulletin*. *5*, 21-33.

Grotstein, J.S. (2007). *A beam of intense darkness: Wilfred Bion's legacy to psychoanalysis*. London: Karnac.

Kernberg, O. 2013, April). *The incapacity to depend: An overview of the treatment of severe narcissistic pathology.*Symposium conducted at the meeting of the San Francisco Center for Psychoanalysis. San Francisco, CA.

Kernberg, O.F. (1975). *Borderline conditions and pathological narcissism*. Northvale, NJ: Jason Aronson.

Kernberg, O.F. (1984). *Severe personality disorders*. New Haven: Yale University Press.

Mitchell, S. A. (1988). *Relational concepts in psychoanalysis*. Cambridge, MA: Harvard University Press.

Racker, H. (1957). The meanings and uses of countertransference. *Psychoanalytic Quarterly, 26*, 303-357.

Rather, L. (2008). Reuniting the psychic couple in analytic training and practice: Theoretical reflections. *Psychoanalytic Psychology*, 25, pp. 99-109.

Rather, L. (2013, April). 'Narcissism and the Analyst's Countertransference'. Invited Discussant for Dr. Otto Kernberg's presentation, 'The Incapacity to Depend: An Overview of the Treatment of Severe Narcissistic Pathology''. The Emanuel Windholz Memorial Lecture. San Francisco Center for Psychoanalysis. San Francisco, CA.

Rather, L (2015). Reflections on James S. Grotstein: An intense beam of light. *fort da*, 21, pp. 14-16.

Rosenfeld, H. (1987). *Impasse and interpretation: Therapeutic and anti-therapeutic factors in the psychoanalytic treatment of psychotic, borderline, and neurotic patients*. London: Tavistock.

Winnicott, D. W. (1965). Communicating and not communicating leading to a study of certain opposites. In *The maturational processes and the facilitating environmen*t, pp. 179-192. New York: International Universities Press, 1965.

Winnicott, D. W. (1941/1975a). Paedeatrics and psychiatry. In *Through paedeatrics to psycho-analysis,* pp. 157-173. New York: Basic Books.

Winnicott, D. W. (1941/1975b). The observation of infants in a set situation. In *Through paedeatrics to psycho-analysis, pp.* 52-69. New York: Basic Books.