

IS THE ANALYST A GOOD OBJECT?

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ABSTRACT This paper suggests that the prohibition against ‘taking the role of the good object’ may inhibit therapists from an appropriate recognition of a loving relation between the patient and themselves. It is argued that the prohibition actually refers to a defensive attempt to get the analyst to take the role of the *idealized* object as a defence against the emergence of bad objects in the transference. This clinical scenario is contrasted with one where the patient needs to find in their therapist a real good object who genuinely cares for them.

Introduction

In this paper I want to address a confusion in the way the term ‘good object’ is used that I consider to be one of the factors that may inhibit therapists from expressing their care and concern towards their patients even when they feel it would be appropriate to do so. I shall show that Melanie Klein does not always distinguish between a truly good object and the defensive use of an idealized object to ward off fears of a bad object. The truly good object is more like a ‘good enough’ object while the idealized good object is required to be a perfect object. These two ways of relating to an object create distinctly different constellations in the transference and need to be handled in different ways by the analyst. Unless the distinction is clarified, there is a danger that the patient’s need for a good object may be stymied by the analyst’s anxiety about being used as an idealized object and by an over-emphasis on the negative transference, when it is the positive transference (and countertransference) that needs to be addressed and interpreted.

In this situation the analyst’s real care, concern and indeed love for the patient becomes a therapeutic factor of the highest importance (cf. Gerrard 1996). If the analyst fails to recognize when the patient’s love and his own response belong to the reality of the analyst as a ‘new object’ (Baker 1993; Stark 1999) and continues to interpret within the transference, the patient may remain stuck, unable to find any confirmation of her own capacity for love, reparation and forgiveness.¹ This implies that the analyst communicates

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to the patient that she is capable of arousing his loving care. As Stephen Mitchell (1993, p. 189) points out, this is not done in a conscious intentional way but is rather something that arises spontaneously out of the interaction – but only if the analyst is free enough from ‘analytic super-ego’ pressures to allow such occurrences to emerge.²

Good versus Idealized Object

It is unfortunate that the idea of the analyst as a good object has become so inextricably linked with issues of collusion and the avoidance of negative transference. For example, I was perplexed when, some years ago, one of my supervisors suggested that I was trying to be a ‘good object’ for a particular patient. It seemed to me unthinkable that I would *not* want to be a good object for my patient. However, I came to realize that my confusion arose (a) because my supervisor was using the term in a very different sense from the meaning it conveyed to me, and (b) the point he was making was that I was *trying* to be something rather than simply allowing the analysis – and the transference – to develop in its own way. His aim was to point out that I was becoming caught up in a countertransference enactment. The difficulty was that I mistakenly heard it as an injunction against being a good object at all. Discussions with many colleagues have convinced me that this confusion was not mine alone. Since it seems to be particularly prevalent amongst trainees and less experienced therapists, I hope that this paper will assist in the process by which therapists develop the confidence to care for their patients without becoming anxious that this involves ‘breaking the rules’.

The injunction against being a ‘good object’ for the patient seems to derive from remarks made by Melanie Klein in *Envy and Gratitude* where she says:

It makes great demands on the analyst and on the patient to analyse splitting processes and the underlying hate and envy in both the positive and negative transference. One consequence of this difficulty is the tendency of some analysts to reinforce the positive and avoid the negative transference, and *to attempt to strengthen feelings of love by taking the role of the good object which the patient has not been able to establish securely in the past*. This procedure differs essentially from the technique which, by helping the patient to achieve a better integration of his self, aims at a mitigation of hatred by love. (Klein 1957, p. 225, my italics)

Klein seems to be referring to an earlier controversy arising from Franz Alexander’s (1946, 1948) proposal that the analyst should provide a ‘corrective emotional experience’. This idea can be traced back even further to Ferenczi’s attempts to meet the needs and longings of regressed patients, arising out of his belief that the analyst’s maintenance of traditional boundaries had the effect of re-traumatizing patients whose difficulties were the result of gross failures in parental care (Ferenczi 1930, 1932).

There are two points to make here. The first concerns the essential difference between the original childhood situation in which the good object has not been securely established and its recapitulation in analysis. Apart from the fact that even the most intensive analysis cannot recreate the parent/child relationship, there is the more salient point that the past cannot be undone. No matter how 'corrective' the experience, the patient has to come to terms with the original failure: the losses of the past cannot be obliterated, they can only be mourned. Furthermore, the analytic situation is not like the original situation in that it *includes* all those past failures and the impact they have had on the patient's life. Unless this is recognized, there is a danger that the attempt to provide a 'corrective' experience may degenerate into a collusion with the patient to avoid the emotional pain of mourning and the necessity of taking responsibility for their own lives.

In this case, the analyst is not *really* felt to be a good object. Rather both patient and analyst are unconsciously plagued by the fear that the analyst (or the patient) may turn out to be another *bad* object – and this is felt to be something to be avoided at all costs. The analyst's attempt to be such an idealized 'good object' represents a defensive piece of acting out in order to prevent the bad object becoming constellated in the transference-countertransference. As Klein says, 'In states of frustration or increased anxiety, the infant is driven to take flight to his internal idealized object as a means of escaping from persecutors' (Klein 1946, p. 9). Thus, the attempt to 'take the role of the good object' creates a kind of idealized *pseudo*-good object in which both analyst and patient may attempt to take refuge. With more disturbed patients whose underlying terrors cannot be pacified in this way, the result may be an escalating malignant regression from which both parties will have the greatest difficulty in extricating themselves (Balint 1968; Stark 1999).

The second point arises from the first because of the way that Klein then fails to distinguish between this kind of defensive, anxiety-driven pseudo-good object and what the experience of a truly good object is like. The difference is clearly brought out by her further remarks on the subject concerning the patient's wish for reassurance:

The patient's strong desire to receive evidence of love and appreciation from the analyst and thus to be reassured, is never completely given up . . . [Identification with the need for reassurance] may also easily tempt the analyst to take the mother's place and give in to the urge immediately to alleviate the child's (the patient's) anxieties. (Klein 1957, p. 225)

Here, Klein seems unaware of the irony that 'giving in to the urge immediately to alleviate the child's anxieties' is no more a recipe for good mothering than for good analysis. The good mother, like the good analyst, is the mother who can *contain* the child's anxieties so that the child learns to bear frustration and disappointment with the security of firm, loving

boundaries. The child then has the opportunity to learn about and integrate painful feelings without them becoming overwhelming and having to be split off and projected. Clearly, this is not what Klein means by 'taking the role of the good object' which turns out to mean behaving like an anxious mother who is herself plagued by guilt, doubt and fear about her own goodness and who experiences the child's demands as a persecution that has to be immediately stopped ('alleviated').

In the situation I have just described, we might imagine a kind of shared phantasy between mother and infant, not of a *good* object but of an *idealized* one – an all-providing mother who meets all needs and alleviates all frustrations. In other words, this is a phantasy in which pain is denied through the demand for perfection. The attempted enactment of such a fantasy of an idealized, all-good object whether in childhood or analysis is almost the antithesis of the conditions that lead to the secure establishment of a good internal object. Indeed, as Klein says earlier in the same paper:

In the early exploration of early splitting processes, it is essential to differentiate between a good object and an idealized one, though this distinction cannot be drawn sharply. A very deep split between the two aspects of the object indicates that it is not the good and bad objects that are being kept apart but an idealized and an extremely bad one. So deep and sharp a division reveals that destructive impulses, envy and persecutory anxiety are very strong and that idealization serves mainly as a defence against these emotions. (Klein 1957, p. 192)

This shows clearly the importance of not colluding with idealizing defences of this kind. However, to describe such collusions as 'taking the role of the good object' is highly confusing. Unless the distinction between good object and idealized object is clarified, analysts and therapists may end up throwing the good baby out with the idealized bath-water with the result that any expression of love, care, concern or even warmth is designated as a 'collusion' to be avoided at all costs. This is likely to artificially intensify the negative transference, giving the analyst the false reassurance that they are doing 'proper analysis'. In fact, all that has happened is that the original negative situation has been recreated with no possibility of ameliorating it. In their zeal to avoid becoming a pseudo-good object, the analyst is left with no room for manoeuvre and willy-nilly becomes a bad object, thus iatrogenically fostering the hatred, envy and destructiveness which then forms the basis for their interpretations.

Warnings against collusions of this kind are often made in Kleinian discourse but in a rather one-sided way.³ For example, Capier refers to:

the analyst's careful avoidance of the manifold collusions with the patient's unconscious fantasies. . . . The patient may perversely idealize these collusions as ordinary sociability or friendliness, common human decency or warmth and empathy. . . . It is therefore quite important to keep in mind, when the patient

feels that one is being 'real' and 'empathic', that one may be unwittingly colluding with the patient's perverse attack on the analyst's and his own, reality sense. (Caper 1992, p. 288)

This makes it look as if common human decency is 'perverse' which is not, of course, what Caper means. What he means seems to me to be more to do with patients who *demand* these things of the analyst and complain that when the analyst is analysing he is not being 'friendly'. As stated, though, Caper's remarks are ambiguous and potentially misleading since they are likely to arouse the anxiety that being warm, decent and empathic is colluding with the patient or, at least, that these feelings should not be expressed. Caper gives no indication of how the analyst may distinguish between real empathy and collusion.

In my view, this depends on careful monitoring of one's counter-transference. Where the patient is attempting to draw the analyst into a collusion, the analyst feels reluctant, yet compelled to act in certain ways, and there is always an atmosphere of guilt, resentment and threat. This is strikingly different from situations in which loving feelings occur in the context of a freedom from compulsion and a sense of space to think with the patient. Then the analyst feels that his activity stems from his own internal free choice, and this creates a benign circle of mutual affection and gratitude between him and his patient which may go beyond 'positive transference' into an acknowledgement of the reality of the good experience that is taking place. For this to happen, though, the analyst needs to be free of super-ego demands in both directions – not only the demand that he should gratify the patient but also the demand that he should not.

I think Caper's remarks could more usefully be put the other way around, viz. 'It is important to keep in mind that, when the patient accuses the analyst of *not* being warm and empathic, the patient may be trying to press the analyst into colluding with the patient's perverse idealizations etc.' This, I think, *is* helpful since it relieves the analyst of guilt and enables him to keep his bearings under this kind of pressure. But it is also important to bear in mind that, when the patient feels one is being warm and empathic, it may be because one *is* being warm and empathic and the patient is able to recognize and be grateful for it.

In this regard, consider another reference from Klein quoted by Caper:

The child's development depends on . . . his capacity to find the way to bear inevitable and necessary frustrations and conflicts of love and hate. . . . He can be immensely helped in childhood by the love and understanding of those around him, but these deep problems can neither be solved for him nor abolished. (Klein 1937, p. 316)

It is important to recognize that Klein is not saying that love and understanding are of no value – far from it, they are immensely helpful. It is just that the deep problems of life cannot be solved or abolished by love, whether

in childhood or psychotherapy. In similar vein, Jung remarks, 'The ultimate questions which worry [the analyst] as much as his patients cannot be solved by any treatment' (Jung 1929, para 170). But the limitation of love and understanding is no reason to eschew their value. On the contrary, it may only be when the patient feels that they are loved and understood that they can recognize their unrealistic expectations of what being loved can provide for them. If the analyst artificially withholds care and concern, this may reinforce the patient's hopelessness or further stir up their resentment in the iatrogenic fashion previously mentioned.

Love versus Idealization in the Transference: Two Groups of Patients

I now want to focus on the clinical differentiation between those patients who attempt to pressure the analyst into acting the role of an idealized object and those who have a real need to experience the analyst's goodness in the form of care, concern and love for them. Although I shall discuss this in terms of two groups of patients, it may also be that this differentiation may occur within the same patient at different times.

In both groups there is an underlying doubt about the existence of a good object and a tendency to seek an idealized good object as a salve to all their doubts, fears and discomforts. However, while in some patients this is expressed as a pressure on the analyst to meet this expectation, in the other group no such pressure is applied. Rather these patients express a sense of hopeless despair that they can ever be loved or even helped and expect the analyst to share their own, very negative view of themselves.

The danger of collusion with the fantasy of the idealized pseudo-good object applies primarily to the first group. These patients are intolerant and fearful of psychic pain and attempt to avoid it by the use of manic defences, especially denial and idealization. It is these patients who seek the 'reassurance' referred to by Klein and who find the process of actually *thinking* about their difficulties so threatening to their precarious psychic equilibrium. They may express the wish to 'get rid of' the unwanted aspects of themselves and to attempt to do so by trying to get the analyst to 'reinforce the positive'. The idea that psychic pain is best dealt with by being confronted and worked through is an anathema to them since they have previously always tried to deal with it by denial, evacuation and so forth. It is these patients who find the suspension of ordinary social conventions so difficult to tolerate and who put pressure on the analyst to be 'friendly' as a way of defending themselves against the emergence of the negative transference. In other words, they try to get the analyst to join with them in their manic defence ('acting out' in the transference, as Joseph (1985) puts it). It is essential that such pressure is resisted since what the patient wants in this regard is directly antithetical to the very nature of analysis.

This may also be a distinction between patients who are predominantly paranoid-schizoid and those whose difficulties are more in the depressive position. In the first group there is an attempt to avoid facing the pain of separateness by clinging to the fantasy of fusion with an idealized good object. In this way the depressive problems of love, guilt and mourning are avoided. By contrast, the patients who may need evidence of the analyst's love are those who are already crushed by depressive guilt and anxiety. These patients are *in* the pain that those in the first group hope to avoid. It is as if those in the first group attempt to barricade themselves within the castle of the 'good object' from where they feel under siege from the bad that threatens them from without. They want the analyst to help them defend the walls and are understandably displeased when, instead, the analyst suggests that it would be a good idea to leave the castle and get to know the world outside. Alternatively, when envy is prominent, they see the analyst as a gatekeeper who prevents their access to the castle while himself enjoying all the good things denied to them. The patients in the second group, however, feel themselves to be permanently excluded from 'good object castle' and unworthy of entry to it. They are dubious and suspicious or even frankly uncomprehending when the analyst suggests that they are actually very welcome at the castle and offers to open the gates for them. It can take many years before they can accept this offer as genuine and begin to accept it. Some of these patients have had so little good experience in their lives that it can take a long time before they are even able to recognize what it is they haven't had and what is on offer in the therapy.

The transference implications for these two groups of patients are quite different. The crucial point is that interpretation of the negative transference only succeeds in maintaining the second group of patients in their excluded and deprived position. What these patients need is a careful understanding of the way they maintain a negative attitude towards themselves, often through a very punishing super-ego function. It may also be necessary to interpret the way they identify the analyst with this function and it is here that it is so important that the analyst does not unwittingly play into it by his own identification with the aggressor in the counter-transference. When the analyst *interprets* the super-ego projection in the transference, he is effectively implying that he does *not* have such hostile/aggressive feelings towards the patient. But such interpretation may not be enough on its own. The patient also needs to have the reality of the positive, loving aspects of themselves and their relationship to the analyst consistently brought to their attention in a realistic way. Furthermore, just as some patients may need to know that they can inspire anger and hatred in the analyst, these patients need to know that they can inspire love and concern. Often, this provokes a revolution in their internal lives that cannot be initiated by interpretation of *their* feelings alone. However 'unanalytic' it may sound, these patients need to know something of what the analyst

feels as well – essentially, they need be loved and, above all, to know that they are loved.

Not that this is a recommendation for the ‘taking the role of the good object’ procedure so censured by Klein. These patients find it hard enough to accept the real thing so they are hardly likely to be taken in by some sentimentalized substitute. Only when they can feel that the analyst really knows just how bad things are for them, only when this has been lived through in the relationship between them, can there be the hope of anything more positive emerging. Any attempt to ‘take the role of the good object’ in the pseudo-idealized sense will be instantly recognized for what it is – an attempt to fob them off with an ersatz substitute.

Clinical Example

I now want to give an example of a patient whose analysis centred on her need to find in me a good object who cared about her. Esther’s childhood experience was one of deprivation, abandonment and neglect. She hoped for better in adult life but was dismayed to find that she struggled to do very much better with her own children and felt guilty that she was failing them and her husband because of her own limited capacity for loving. This brought her to therapy but she was dubious as to what therapy could do since she felt herself to be so ridden with envy, resentment and spite as to be more or less unlovable and irredeemable.

Initially, there was a period of hope and optimism in the therapy – a kind of honeymoon period. Very soon, though, Esther became disillusioned and complained that she had lost faith in me, that I wasn’t helping her and perhaps I didn’t even really care about her and her therapy. She began to sink into a state of hopeless despair that she could ever change. My attempts to interpret her destructiveness and her envious spoiling only succeeded in provoking angry and resentful accusations that she did not need me to tell her how bad she was – she already knew that perfectly well.

At one point, I interpreted her despairing feeling that her inner life had dried up and she had nothing to bring to the sessions as due to destructive attacks on her own mental functioning (attacks on linking etc.). In the following session she told me that she ‘had protested from the depths of her being’ against this interpretation. In fact, I had been speaking out a sense of helpless desperation, clutching at straws in the hope of finding *something* that I might say to alleviate her despair, something that she was herself *doing* to produce her internal misery and therefore might not do. Her response showed me that I had instead merely succeeded in getting caught up in her negativity and had unconsciously identified with her critical and destructive view of herself. This was further clarified by a dream. She was told that a certain man would be coming to live with her but she did not want him to because she knew he was involved in some kind of corrupt plot.

Again I interpreted the man as representing her own corrupting, spoiling aspect, but now I was also careful to distinguish between what she called 'all the nasty things under the stones' and the corrupting influence that made them – and me – appear to her in that light. I pointed out that she saw only her destructive aspects but not her loving ones – and *that* was the corruption. Here I drew on the positive link between us rather than, say, interpreting the corrupt man as a transference fantasy about me. However, for Esther the proof of this positive link lay in the fact that, contrary to her expectations, I had not given her my usual 'grim look' in this session but had actually smiled at her. My spontaneous smile, of which I was hardly conscious, became very important to Esther on several occasions, especially since it contrasted with her experience of a mother who was never pleased to see her. In this way I repeatedly contradicted her transference expectation, not merely by interpretation but also by behaving naturally and spontaneously, in fact, simply by being myself.

Experiences such as this showed me that what Esther needed was for me to stand firm in my conviction of her goodness and loveliness in the face of all her protestations to the contrary. Sometimes this meant showing her a more compassionate response than the one she expected or gave to herself. Sometimes it meant simply being with her sense of emptiness and despair and accepting that I could not understand or ameliorate it. Sometimes it also involved refusing to provide 'tokens' of my care since that would have implied that the care I was already providing was insufficient. And, later in the therapy, it became possible – and necessary – to challenge her unyielding and unforgiving self-punishment with some force. Ironically this self-punishment stemmed from an exaggerated (idealized) sense of goodness, against whose standard she felt utterly guilt-ridden. I interpreted this as a form of *pride*, as if she were meting out a judgement on herself that belonged only to God. On one such occasion, she had been to the cathedral near my consulting room before the session. She talked of the beauty and goodness she had felt there but that it felt unavailable to her – she was always pulled back again into Hell. I told her that she was cutting herself off from these things because she felt she did not deserve them. I did not dispute the fact that she had done bad things but told her that I objected to her 'taking the law into her own hands', taking it upon herself to mete out judgement that belonged only to God and in so doing cutting herself off from God. She was, I reminded her, herself one of the children (God's children?) she felt so guilty about damaging and it was therefore up to her to treat herself with more kindness.

In these various ways, there was the same process going on in the transference that Strachey (1934) describes as underlying the mutative interpretation. Strachey argues that the patient projects a critical super-ego; when the analyst interprets this instead of enacting it, the patient is able to differentiate the real object of the analyst from the 'external phantasy object' of their

projection. My point is that this can be achieved in many more ways than transference interpretation *per se*. The whole manner of the analyst's being and his consistent care for and faith in the patient are all the time drawing this distinction and enabling the internalization of a more benign super-ego without this necessarily being interpreted in the transference. I might say that, with Esther, I spoke *out* of the transference rather than *into* it. For example, it would have felt leaden and unnecessary to make explicit the link between God's cathedral and my consulting room. The language of God spoke much more directly and powerfully to her at this point than any 'translation' into the language of the transference. What was essential was that I did not get caught up in identification either with the 'grim look' of the super-ego (God's wrath?) nor collapse in despair against its onslaught.⁴

Gradually she began to recognize that there might be a difference between the idealized object she had hoped I would be and the truly good object I might actually be for her. It became apparent that it was difficult for her to find the good object because it was difficult to *recognize* it, as opposed to the hoped-for idealized object that always eluded her. She would oscillate between the hope that I did care for her and the despair that I did not and could not. Then she would rebuke me for what she called 'your bloody optimism', and indeed there were times when I did feel that perhaps she was right and I didn't understand just how bad things were for her. In the end, it was only through my being with her in the painful absence of the (idealized) good object that she could experience its presence as a good enough object. I think too that her sense of emptiness was sometimes the result of giving up her attachment to an idealized but frustrating object and allowing an internal space where a good object might be.

She became obsessed with rounded shapes – vases, jugs, bowls and, especially, the spherical lamp-shade and wooden apple on the table of my consulting room. This initiated a very regressed period in the therapy when she struggled to give up her self-punishing, internal relationship and turn instead to the archetypal good breast-mother represented by the round shapes and by me in the transference.⁵ Whether this was a re-finding of the lost good object of infancy or the emergence of an archetypal potential *ab novo*, the contrast with her previously known experience was acute and thus increased her sense of mourning for what she had not had. Yet she still could not bear to hold on to the sense that I cared because she could not bear the hurt and disappointment when I let her down. It was not any particular thing I did or didn't do that mattered – more than ever it came down to the question of whether she mattered to me, whether I cared, whether, in fact, I was a good object.

The crucial denouement was initiated by an occasion when I reminded her that she had not given me her cheque. She was immediately outraged by what she saw as my selfish greed. In vain did I remind her of a previous occasion when she had been distressed because she had forgotten to pay me

after a break and I had *not* reminded her. Ironically, I had reminded her out of a wish to protect her from distress! For her, my intervention meant that she could not trust me and that I didn't care about her.

In the following sessions, she spoke of feeling that something beautiful and fragile had been shattered – the beautiful illusion that I cared for her (perhaps a reference to the beauty of the rounded shapes). 'I needed to believe that you cared', she said, as though it could *only* be an illusion. I said that only *perfect* care was an illusion and, since I wasn't capable of that, she felt unable to accept the kind of care that might genuinely exist even though I might make mistakes or be 'greedy' as she put it. 'I'm not the mother you didn't have,' I told her, 'but I am the therapist you do have'. Over the following weeks, I came to understand that, when the original care has not been good enough, good enough care no longer feels good enough. Only perfect care would protect her from feelings of hurt and rejection and, inevitably, this is never available. Hence, as Klein originally argued, it is futile to attempt to provide it since that only avoids the necessity of mourning. And without mourning, the patient can never give up the attachment to the frustrating, idealized object and turn instead to the good enough object that *is* available.⁶

A few months after the incident with the cheque, Esther brought her cheque to the first session of the month in the usual way. She referred back to the previous incident saying she didn't mind any more that I was greedy because she knew she was greedy too. I said I was not greedy and neither was she. She then mentioned my having criticized her for not paying. I again stated that I had not been criticizing her. This time she was able to hear me and said it was important I should say so since her husband too often said that she accused him of things that he hadn't done or hadn't meant.

She went on to wonder what would happen if a situation arose so that she couldn't pay me. She mentioned someone she knew whose therapist had referred her to a low-fee clinic when she had not been able to continue paying. She supposed that didn't matter as her friend hadn't been going for long and so the 'transference' wouldn't have developed much. I felt there was a significant kind of 'distancing' in this comment and so I said there was an important difference between thinking in terms of transference and thinking in terms of relationship. 'If you think of your relationship with me in terms of "transference", it means that all you can rely on in me is my professional responsibility since transference implies something that is unreal, an artefact of the work and not to do with me personally. But relationship is the opposite – it implies something that is real, something that both of us are involved in and so that means that you matter to me.'

I had not thought that I was saying anything especially significant or new in making this comment but the reaction was dramatic – it was the moment of truth. Esther said she felt as if an arrow had pierced her, that I'd given her the thing she thought she wanted but it had caused her great pain and

challenged her whole mental organization. It was, she said, like the language people use to try to convey the effect of a religious revelation – metaphors of howling winds or earthquakes. It was something she thought she'd probably never felt before.

Although, in saying this, I was making an ordinary and almost matter of fact remark, I was also expressing a deep personal conviction about the therapeutic process. That does not mean that what I said was not addressed personally to Esther since I was also speaking out of a deep personal involvement with her that had already gone on for some years and would continue for several more. She had touched on some of my own deepest concerns more than she knew, and probably more than I knew: how could she *not* matter to me?

From this point on, Esther was able to maintain her belief in my care and this also enabled her to become more caring and compassionate towards herself. This might be described, in Strachey's terms, as the introjection of a more benign super-ego. There was, of course, no miraculous recovery: she was not immune from the internal assaults of her envy and self-punishing guilt, but she was more able to hang on to the sense that these were temporary and would pass. The mourning she had gone through for the shattered illusion of the idealized object was also a crucial element in this process. Having become able to accept a dependent relation to a good enough object, she became more able to accept the good enough aspects of her self. There was a noticeable shift towards a more benign view of the world, indicating a more realistic view of what she had previously denigrated as 'your bloody optimism'. This could also be described as a movement from a wished-for idealized object relationship to an actually experienced good object one.

Conclusion: The Real Good Object

If and when analysis provides a corrective experience it does not do so intentionally or deliberately.⁷ The analyst does not *try* to be a good object. Rather he responds to the patient out of his own immersion in an analytic process whose outcome he cannot prejudge. Michael Fordham suggests that it involves a process of deintegration out of the (analyst's) self: 'What is put at the disposal of patients are parts of the analyst which are spontaneously responding to the patient in the way he needs' (Fordham 1957, p. 97).

In this way, the analyst becomes a good object, not by gratifying the patient's every demand or by trying to 'second-guess' what he or she needs and provide it for them, but *by virtue of being a good analyst*. The question is, of course, what is a good analyst? And to answer that, we must look at what is therapeutically effective.

I believe the essential therapeutic factor in Esther's analysis was my determined refusal to be deflected from a steadfast belief in her capacity for goodness and that this cannot be fully comprehended within the framework

of transference–countertransference. It is not merely something that belonged to Esther and was ‘projected’ into me (syntonic countertransference), nor was it an extraneous intrusion of my own personal material (neurotic countertransference or illusory countertransference). Rather it was something that emerged out of the unique interaction between us – it was the something extra of my self that Esther called forth from me. I can recognize the functioning of this deep personal conviction in my work with other patients too, as well as recognizing other aspects of myself that are called forth in different situations. Similarly, other analysts may bring different personal qualities, different personal convictions to bear on their work. For some, if not for me, this may be a deep conviction about the therapeutic value of working entirely in the ‘here and now’ transference. The point is that the therapeutic factor is the personal conviction itself, not the technique. As Jung says, ‘The fact of being convinced and not the thing we are convinced of – that is what has always, and at all times worked’ (Jung 1929, para 167). Jung argues that:

Every psychotherapist not only has his own method – he himself is that method. *Ars requirit totum hominem*, says an old master. The greatest healing factor in psychotherapy is the doctor’s personality. (Jung 1945, para 198)

I take it as given that a good analyst will behave in a highly disciplined and thoughtfully considered way, including the maintenance of firm boundaries. His technique, though, should be like a musician’s – not to restrict him but rather to free him to express the music that is within him. An undisciplined expression of ‘personality’ is just as unsatisfactory as a musician who feels the music deeply but cannot play in tune. Just as the inspired musical performance expresses not only the spirit of the composer but the unique personal interpretation of the performer, so the analyst’s particular form of understanding and the way this is conveyed needs to be a unique and personal one if it is to inspire and convince the patient.

When the patient is able to use the analyst in this way and feel genuine gratitude for something freely given and received, then what takes place is a new experience – Balint (1968) calls it a new beginning. This may be ‘corrective’ in its own way but it is not deliberately or consciously so. Nor, in my view, is it primarily a matter of ‘internalization’ – the experience of the therapeutic relationship itself has a direct impact on the patient’s inner world, vividly portrayed by the ‘revelation’ that Esther described as like an earthquake. Such an experience strengthens the patient’s belief and confidence in the goodness which exists in the world as well as in their own intrinsic goodness (worth, value, etc.).

It was in this sense that I found it unthinkable when my supervisor seemed to be suggesting that being a good object was no part of being an analyst. Yet, in this sense, no-one has ever, to my knowledge, suggested that the analyst is *not* a good object, least of all Melanie Klein and her followers.

Betty Joseph, for example, refers to whether or not the patient is able to perceive the analyst as a 'helpful object' (Joseph 1985, p. 451). Caper speaks of the analyst helping the patient to integrate split-off parts of his personality and refers to Meltzer's analogy of the analyst as gardener, weeding and watering so that each plant might develop to its full potential (Caper 1992, p. 289).

Herbert Rosenfeld (1987) goes further, emphasizing the need to interpret the patient's defences against the 'good dependent relationship' with the analyst. This certainly implies that the analyst is a good object on whom the patient might depend, that the good object is not just another 'external phantasy object' but the actual reality of the good analyst. The patient cannot make a good dependent relation on a good object, cannot discover her own capacity for love and gratitude unless the analyst *is* a good object that does really care for her. Most of the time, analytic work is concerned with removing the obstacles that prevent the patient allowing herself to have this experience. One might compare this to the musician practising their scales – they are a means to an end, not an end in themselves. We should not become so immersed in the technical means, vital as they are, that we forget their ultimate purpose. Perhaps it is because the experience is so ineffable that many analysts seem reticent to speak of it. Yet there is a danger that this will be taken as implying that it does not exist or is not important.

All this implies how important it is that the analyst goes on being human and ordinary and does not succumb to super-ego demands, whether their own or the patient's, to be more than ordinary, especially the demand to be a perfect analyst. The emphasis on the dangers of attempting to play the role of the good object is only one side of this danger. Equally important is that the analyst does not attempt to be a perfect analyst who only ever analyses and interprets and who, in their zeal to maintain 'boundaries', becomes cold, rigid and remote, inhibiting and disallowing their ordinary humanity, including their capacity for love and hate, sorrow and remorse, confusion and doubt, fear and joy. Being human and ordinary is actually a pretty scary way to be with the patient since, as Jung says, one cannot hide behind the mask of the analytic role (Jung 1929, para 163). In the heat of the encounter with the patient one has no certain guide as to how to be, what to say or what to do. On the other hand, being able to allow for one's own human fallibility and, perhaps even more important, being able to allow the patient to see this seems to me to offer an invaluable aid to the patient's struggle to free themselves from their own omnipotent expectations.

Notes

1. As the writer is male and the clinical material discussed later in the paper concerns a female patient, I have, for the sake of simplicity and clarity, referred to 'the analyst' here as 'he' and the patient as 'she'. In all other respects such nomenclature is, of

course, arbitrary and implies no gender specificity with regard to either analysts or patients.

2. The inhibiting effect of the analytic super-ego is considered in a subsequent paper where I show how persecutory anxieties arising in the clinical situation are reflected and reinforced in psychoanalytic culture and organizational life (Colman, forthcoming).

3. See *The Analyst's Pre-Conscious* (Hamilton 1996, chs 3, 4) for examples of Kleinian and Freudian analysts discussing their suspicion of 'the real relationship' in terms of 'seduction'.

4. cf. Winnicott's emphasis on the analyst who survives but does not retaliate (Winnicott 1969, pp. 107–8).

5. cf. Rosenfeld (1987) re: the good dependent relationship with the analyst.

6. cf. Winnicott:

Corrective provision is never enough. . . . In the end the patient uses the analyst's failures, often quite small ones, perhaps manoeuvred by the patient The operative factor is that the patient now hates the analyst for the failure that originally came as an environmental factor, outside the infant's area of omnipotent control, but that is *now* staged in the transference. So in the end we succeed by failing – failing the patient's way. This is a long distance from the simple theory of cure by corrective experience. (Winnicott 1963, p. 258)

7. Stark points out that the ill-repute of Alexander is due to his idea of the analyst deliberately taking a stance in opposition to the parents' 'traumatogenic' one (Stark 1999, pp. 298–9).

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