

# **The therapist's container in practice**

Natalia Petrovna Solovieva

Submitted in partial fulfilment of the requirement  
of the degree of Master of Health Science

School of Psychotherapy  
Auckland University of Technology

September 2007

This dissertation is dedicated to my partner Mark Bond  
whose love, encouragement and commitment to my work made this writing possible

# CONTENTS

<b>CONTENTS.....</b>	<b>I</b>
<b>ACKNOWLEDGEMENTS.....</b>	<b>IV</b>
<b>ABSTRACT .....</b>	<b>V</b>
<b>INTRODUCTION.....</b>	<b>6</b>
CLINICAL PROBLEM.....	6
STUDY BACKGROUND: PERSONAL ACCOUNT .....	6
STUDY BACKGROUND: PROFESSIONAL ACCOUNT .....	7
STUDY BACKGROUND: CONCEPTS AND THEORY. THE THERAPIST’S CONTAINING CAPACITY .....	9
TAKING THEORY ONE STEP FURTHER: THE THERAPIST’S ATTACK ON LINKING AND CONTAINING .....	10
ORGANISATION OF THE STUDY .....	11
<b>METHODOLOGY.....</b>	<b>12</b>
INTRODUCTION.....	12
METHODOLOGICAL APPROACH.....	12
SYSTEMATIC LITERATURE REVIEW .....	13
<i>Scope of the search</i> .....	13
EXPERT INTERVIEW .....	14
ETHICAL ISSUES .....	15
THEORY BUILDING .....	15
CONCLUSION.....	16
<b>CHAPTER ONE: THE CONCEPT OF CONTAINMENT IN THE WORKS OF WILFRED BION AND CONTEMPORARY PSYCHOANALYSTS .....</b>	<b>17</b>
INTRODUCTION.....	17
THE ORIGINAL CONCEPT OF ‘CONTAINER-CONTAINED’ .....	17
RELATIONAL VARIATIONS BETWEEN CONTAINER AND CONTAINED.....	19
DAMAGED CONTAINER.....	20
CONTEMPORARY DEVELOPMENTS OF THE CONCEPT OF CONTAINMENT .....	22
<i>Container-contained relational variations</i> .....	22
<i>Types of the container</i> .....	23
CONTAINING AND INTERPRETING .....	24
CONTAINING AND HOLDING .....	26
CRITIQUE OF THE CONCEPT OF CONTAINING.....	27
CONCLUSION.....	28
<b>CHAPTER TWO: THE THERAPIST’S CONTAINING CAPACITY AND ATTACKS ON LINKING.....</b>	<b>29</b>
INTRODUCTION.....	29
CONTAINING, LINKS AND ATTACK ON LINKING IN THE THEORY OF WILFRED BION .....	29
THE THERAPIST’S NEUROSIS AND FEAR OF MENTAL PAIN .....	32
OVERIDENTIFICATION WITH THE PATIENT .....	33
THE THERAPIST’S NEED TO CURE.....	34
THE THERAPIST’S NARCISSISTIC ASPIRATIONS.....	35
THERAPIST’S WORKING THEORY .....	37
CONCLUSION.....	39
<i>Clinical vignette</i> .....	39
<i>Summary</i> .....	40
<b>CHAPTER THREE: ON ENHANCING THE THERAPIST’S CONTAINING CAPACITY .....</b>	<b>41</b>
INTRODUCTION.....	41
BION ON ENHANCING THERAPIST’S CONTAINING CAPACITY .....	41
OTHER THEORISTS ON ENHANCING THERAPIST’S CONTAINING CAPACITY .....	43
<i>Preventing therapists’ own neurosis from attacking the containment</i> .....	43
<i>Working through therapists’ overidentification with their patients</i> .....	43
<i>Developing therapists’ reverie</i> .....	44
CONCLUSION.....	46
<b>CONCLUSION.....</b>	<b>47</b>

CLINICAL VIGNETTE.....	47
SUMMARY .....	48
WHAT I HAVE LEARNED .....	49
<b>REFERENCES.....</b>	<b>50</b>
<b>APPENDIX A .....</b>	<b>57</b>

**ATTESTATION OF AUTHORSHIP**

I hereby declare that this is my own work and that to the best of my knowledge and belief, it contains no material previously published or written by another person or material which to a substantial extent has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements.

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_

## ACKNOWLEDGEMENTS

I would like to gratefully acknowledge all those who assisted and supported me on this journey.

Firstly I would like to express my heartfelt thanks to my supervisor Associate Professor Stephen Appel for his intuitive guidance, wise advice, stimulating discussions, patient editing and words of encouragement when things got too hard.

I sincerely thank Neville Symington for sharing his experiences and knowledge, as well as the time taken to accommodate our interview and email communication given his tight schedule.

I thank Amber Davies and Andrew Kirby for their invaluable and honest feedback in our group supervision meetings.

I would like to extend my thanks to Shoba Nayar for taking time to read my dissertation and provide invaluable editing assistance and advice.

To all my friends and colleagues who took time to read each chapter as it took form, cook me dinners and wipe my tears at the times of writing blockage I am very grateful.

Ethical approval to proceed with this research was granted by the Auckland University of Technology (ethic application numbers 04/07 and 02/33).

## **ABSTRACT**

The practice of psychotherapy involves the interaction of two personalities and realities. This dissertation focuses on the experiences of the therapist; largely his ability to contain and his contribution to his own emotional experiences.

Viewed primarily through the lens of Bion's theory, accompanied by an expert interview with Neville Symington this systematic investigation explores containment in practice; and equally how the containing capacity might be diminished through the therapist's own 'attacks on linking'.

Clinical recommendations are made on how therapists' containing capacity can be enhanced, as well as how therapists' attacks on linking can be prevented. The results of the study contribute to an understanding of the interpersonal and intersubjective nature of the therapeutic relationship where both therapists' and patients' contributions must be considered.

## INTRODUCTION

So I note this and trust that some psychic healing may begin once the sick area in me has been diagnosed. (Symington, 2004, p. 261)

### **Clinical problem**

Miss J, 18, was referred for psychotherapy by her family doctor. She arrived for the initial interview with her boyfriend and insisted that he came into the room with her. She stated there was nothing wrong with her and that she could not understand why she needed therapy. The only thing bothering her was that she was getting upset and was crying for no obvious reason. She described how people around her did not understand her, for instance, people did not respect her compulsive needs for everybody to have exactly the same portion of rice and chicken for dinner, and if only her father would not cook against her orders because he would leave the kitchen in a mess. My response was to empathically reflect how hard it was for her not to be heard. On a few occasions, when Miss J rearranged the boxes of tissues in perfect order, or when she brought her boyfriend without prior discussion, I had a vague sense of irritation which I unwittingly suppressed. My attempts at being a good and loving therapist meant my client continued seeing nothing wrong with herself, whereas I was left with uncomfortable negative feelings that I could not quite grasp.

### **Study background: personal account**

My main purpose in doing this study was to explore the difficulty I experienced in practicing psychotherapy where I struggled with bearing difficult emotional experiences such as anger, hostility, envy, jealousy, shame, love or joy. I noticed that I tended to avoid, deny, brush away or 'swallow' feelings that were either painful or of which I disapproved. At times these feelings were outside of my awareness and only later on, in supervision or in personal therapy, could I connect to them. Although I was aware that some of the difficulty I was having with allowing myself to feel the feelings had to do with my own unresolved conflicts, through supervision and some preliminary research it became apparent that I was not the only one struggling with these feelings.



## **Study background: professional account**

Therapists experience the gamut of emotions in their daily work. Along with objectivity, neutrality, warmth, and confidence in being helpful, therapists can experience irritation at patients acting out, fear at suicidal impulses or discomfort at their sexual seductiveness (Aaron, 1974). Therapists can be bored, flattered, gratified, or frustrated by their patients. Stern (1989) suggests that the difficulty therapists often have is not only in formulating their experiences in words, but also in knowing what their experience is and what it means. The therapist's primary problem is not in selecting a correct interpretation but in "how to sense that there is something there to interpret" (p. 14).

"Therapist emotion is at times viewed as synonymous with countertransference or, at very least, as one of the main inroads to understanding countertransference" (Homqvist & Armelius, as cited in Najavits, 2000, p. 322). Therapists' emotional experiences are often seen as evoked by their patients via mechanisms like projective identification (Frederickson, 1990; LaFarge, 2000; Ogden, 2004b) where the patient gets rid of unwanted mental contents by projecting them onto the therapist and the therapist identifies with the induced feelings. The therapist<sup>1</sup> then feels occupied by a state of being that he can not fully identify or reflect upon and finds it difficult to bear. Hoffman writes that, "the analyst in the analytic situation is continuously having some sort of personal affective reaction that is a response to the patient's manner of relating to him" (cited in Stern, 1989, p. 15). The therapist regularly develops a countertransference neurosis, which is stimulated by the patient and which he is often not aware of: but must cure himself of, if the patient is to be cured (Racker, cited in Stern, 1989).

Among the variety of other views on countertransference two classical views on the sources of it are the matters of interest to this study. In the first, it is considered to be the therapist's unresolved neurosis (Freud, 1910; Reich, 1951). In the second, it is the patient's creation of the therapist's reactions (Heimann, 1950). Faimberg (1992) challenges these views by introducing a concept of the countertransference position as the "psychical activity of the analyst intended to restore what corresponds to the history of the transference" (p. 542). She suggests that the patient cannot create the therapist's

---

<sup>1</sup> For the ease of writing and to avoid confusion both therapist and patient will be referred in male gender.

response alone, but can create the conditions for the therapist to respond that will impact on the therapist's own psychical functioning. Although the described difficulties lie in the area of countertransference in its broadest sense, in this study I will focus on the therapist's contributions to the way they deal with their feelings rather than on a one-person model of countertransference where the therapist's reactions are determined by the patient's projections only (Heimann, 1950). For example, therapists can enter into unconscious agreements with their patients to avoid conflict or confrontation in the therapeutic relationship and in the content of interpretations. Thus a relationship is developed which is marked by an exaggerated accommodation of the contained, by excessive reasonableness and misleading gentleness (Lamanno-Adamo, 2006; Maldonado, 2003).

Often the patient's affective state and his contribution to the therapeutic encounter are emphasised, thereby backgrounding how the therapist's affective state has a strong power to shape the relationship. Equally important is the necessity to recognise that the therapist's narcissistic needs, current personal circumstances, as well as his defences, contribute to countertransference. Therapists' feelings, when unacknowledged or inadequately addressed, may have devastating consequences, such as sexual acting out or making an opponent out of the patient (Najavits, 2000). The therapist's daily experience of tolerating the patient's loving and hateful feelings and responding to them therapeutically can be a constant strain (Aaron, 1974). When these feelings are promptly acknowledged and adequately addressed, they may serve as a therapeutic resource (Pope & Tabachnick, 1993). Winnicott (1951/1994) insisted that therapists must not deny feelings that really exist and that the denial of them can lead to "therapy that is adapted to the needs of the therapist rather than to the needs of the patient" (p. 356).

Although therapists' emotional responses have been emphasised as crucial for most of the century, there is very little empirical research on therapists' countertransferential emotions (Najavits, 2000). Few studies touch on difficulties in researching therapists' countertransference. Pope and Tabachnick (1993) suggest that certain feelings like anger, hate, fear, and sexual attraction can be uncomfortable, complex and difficult to acknowledge and have been largely neglected in the research literature. The discomfort of beginner therapists with their emotions in treatment (Najavits, 2000), shame and guilt experienced by therapists about their countertransference (Aaron, 1974), fear of repercussions of supervisors and embarrassment of not fitting with the stereotypical

image of a professional therapist (Najavits, 2000) are all obstacles in researching therapists' emotional experiences.

### **Study background: concepts and theory. The therapist's containing capacity**

A downside of the recent importance of countertransference is that therapists are encouraged to assign responsibility for how they feel to their patients and thus not think about their own contributions to their painful emotional experiences and their capacity to contain these reactions. "Most particularly, we fear the unknown, in ourselves as much as in our patients, and are averse to embracing unconscious as well as conscious emotional knowledge" (Bion, as cited in Billow, 2000, p. 422).

In this study I will follow Steiner (1994) and Symington (1996) in thinking about therapists' countertransferential feelings as complicated by their own mental reality. The conceptual tool I will employ to think about these struggles is Bion's (1962a) concept of "container-contained", where the therapist plays the role of container for painful experiences the patient (and the therapist) find difficult to bear. Bion's view (1962a, 1962b, 1963) is that the therapist must function as an active container and metaboliser of the patient's projective identifications and projected inner contents, which often test the therapist's ego strength to deal with his own instinctual tensions.

Billow (2000), following Bion, insists that rather than eschew personal emotionality, the therapist must embrace it. This is a painful task, not easily achieved or sustained. Bion characterised therapy as involving "two rather frightened people; the patient and the psychoanalyst. If there are not, one wonders why they are bothering to find out what everyone knows" (cited in Billow, 2000, p. 411). The suggestion is that therapists as much as their patients are often afraid of realising unrealised thought and emotion. "Like the patient, the analyst approaches thinking with trepidation, and consequently makes unconscious 'decisions' at various moments to evade, modify, or modulate the mental pain arising from tolerating emotional experience" (Billow, 2000, p. 411).

Quinodoz, Aubry, Bonard, Dejussel, and Reith (2006) suggest that therapists can unconsciously resist connection to the feelings that appear to be negative or those that remind them of their own anxieties and difficulties. Billow (2000) writes about therapists' fear of primal feelings, which are often intense and frightening in their

‘unadulterated’ quality. Both the patient and the therapist tend to avoid mental pain. In order to overcome this temptation, therapists need to reach their own painful feelings, which requires ‘moral courage’ (Symington, 1996, p. 50). Bion argued that all therapists are ‘bad’ therapists with a ‘good’ therapist trying to get out (cited in Billow, 2000). He meant that therapists do a ‘bad job’, not because they lack skills, but because they “suffer human limitations” (Billow, 2000, p.422).

### **Taking theory one step further: the therapist’s attack on linking and containing**

Bion (1967/1984) wrote about patients’ inability to contain psychological pain and getting rid of it into the therapist, where the therapist as an active container bears the pain and gives back the painful emotional experiences to the patient in the way the patient can bear and contain. He (1959a) suggested that in some cases patients attack therapists’ ability to think and do psychological work with those contents, and named this patients’ ‘attack on linking’. Applying modest theory building, I propose that not only can patients attack therapists’ capacity to contain, think and link one object with another, but that therapists themselves can contribute to the inhibition of their linking, thinking and containing capacity. In other words, an extrapolated concept of therapists’ attack on linking is proposed.

A variety of aspects of therapists’ mental lives can become attacks on linking. Billow (2000) suggests that the feeling of being “the professional” can get in the way of therapist spontaneity and passion. Therapists’ fear of primary feelings and emotional pain can also attack their containing and thinking capacity. Both Bion (1967) and Symington (1996) consistently caution therapists about clinging to theories that prevent them from connection to their own and patient’s experiences, and being open to a new knowledge and those as yet unknown primal painful feelings.

Racker (cited in Epstein, 1977) insisted that therapists “must begin by revision of our feelings about our own countertransference and try to overcome our infantile ideals more thoroughly, accepting more fully the fact that we are still children and neurotics even when we are adults and analysts” (p. 447). Patients struggle with bearing emotional pain; I argue that when therapists’ containing capacity is improved, patients will be able to increase their mental and emotional capacity to bear the unbearable.

## **Organisation of the study**

This introduction discussed the therapist's struggles in dealing with difficult emotional experiences as the research issue. The next section of the study will discuss methodology utilised to explore the formulated issue. In the first chapter to follow Bion's concept of therapists' containing capacity will be explored as a conceptual tool to think about the difficulties therapists experience in dealing with painful emotional experiences. Chapter two will explore what gets in the way of therapists containing and experiencing difficult feelings. These inhibitions will be thought about expanding Bion's concept of attacks on linking. Chapter three will discuss how therapists' capacity for containing can be enhanced, incorporating an expert interview with Neville Symington. The entire study will conclude with a brief conclusion and an account of my own learning.

## **METHODOLOGY**

### **Introduction**

This chapter outlines the methodological approach and methods best suited to explore therapists' containing capacity. The methodological approach and rationale for its implementation are discussed, including the use of triangulation to enhance the validity of the chosen qualitative method. Three research methods will be utilised to explore the issue: (a) the principal tool, the modified systematic literature review, (b) a brief expert in-depth interview, and (c) a modest theory building method.

### **Methodological approach**

Of the two major theoretical paradigms, positivism and phenomenology, (Taylor & Bogdan, cited in Patton, 2002) it is the latter that has been heavily relied upon in building psychotherapy research, theory and practice (Milton, 2002). Phenomenology includes the interpretative paradigm and predominantly utilises qualitative research. Although it challenges the deterministic and reductionist approach to human experience, seen in positivism, it is often criticised for its lack of objectivity and generalisation. As this study is exploring the mental phenomenon of containing developed in psychoanalytic theory, it will use the interpretive framework and explanatory<sup>2</sup> type of research (Ruane, 2005) with qualitative methods including modified systematic literature review, expert interview and theory building.

The phenomenological paradigm and its methods allow the researcher to overcome the limitations of positivistic causal explanations and empirical generalisations applied to complex internal personal and interpersonal phenomena of the psychotherapeutic encounter. Given that the concept of containing was developed as part of psychoanalytic theory and is extensively utilised by psychotherapists in reflecting on their practice (Boris, 1986; Willoughby, 2001), methods of systematic literature review and expert interview are identified as fully suitable to study this issue. In this study the process of

---

<sup>2</sup> Ruane (2005) identifies three general types of research: explanatory, descriptive and evaluation research. For this study the explanatory type of research is best suited as it is conducted in the interest of "getting to know" or increasing understanding of a new or little researched phenomenon.

triangulation<sup>3</sup> is employed, where the systematic literature review is combined with an expert interview to enhance validity.

### **Systematic literature review**

Systematic literature reviews have been used in the social sciences for many decades to inform theory and practice (Petticrew & Roberts, 2006). The systematic review closely adheres to a set of methods to limit the researcher's bias by identifying, appraising and synthesising all relevant studies in order to answer a research question. Systematic reviews provide "a key source of evidence-based information to support and develop practice as well as to support professional development – for example, by helping to identify new and emerging developments and gaps in knowledge" (Petticrew & Roberts, 2006, p. 13). The results of a single study taken in isolation can be seriously misleading; especially in psychotherapy research which is often single case study based, hence, the importance of systematic reviews.

In this study a modified systematic literature review will be utilised to make sense of large bodies of information, and as a means of contributing to further exploration and thinking around the research question and its implication to practice. The systematic approach will assist in minimising the individual researcher's bias and to produce a summary of the available evidence relevant to the research question. It is important to note the limitations in reliability and validity of the reviewed data, which is predominantly case study based and can be subjective.

### ***Scope of the search***

At the beginning of this study there was no clearly defined research question. Via supervision and personal therapy, the issue I was dealing with in conducting therapy with my patient gradually crystallised into a countertransferential issue and my own capacity to bear difficult emotional experiences. In my case those experiences were predominantly anger and hostility, however I realised that it could be any painful experience or feeling that a therapist might find difficult to bear, such as love or gratitude. A preliminary search was undertaken to crystallise the issue I was dealing

---

<sup>3</sup> Triangulation is the process of using a combination of research methods, or combination of different participants or different data sources (Greenhalgh & Taylor, 1997; Patton, 2002).

with into the problem of the therapist's containing capacity and its obstacles. The preliminary research informed my systematic search, which aimed to explore the therapist's containing capacity. The criteria and outcomes of both the preliminary and the systematic searches can be found in Appendix A. Taking into account the search limitations discussed in Appendix A, this study is an attempt to present a comprehensive and reliable overview of the psychoanalytic literature on the subject of the therapist's containing capacity.

## **Expert interview**

The systematic review is supplemented with a face to face interview with Neville Symington, a former supervisee of Bion and himself a well-known and influential psychoanalyst. Interviewing a recognised professional from the field created an additional source of data, but most importantly helped to support and guide my own thinking and exploration. Neville Symington was chosen as a subject for the interview as in his works he openly and critically reflects on therapists' contributions to the therapeutic experience. The interview is an elaboration of the systematic review findings.

According to Gubrium and Holstein (2002) in-depth interviewing commonly seeks "deep" information and knowledge and rarely constitutes the sole source of data in research. They suggest using it to check out theories the researcher has formulated or to further explore phenomena about which the researcher has some prior knowledge. As the purpose of this exploratory study is to investigate the research question in detail, the in-depth interview was considered a valid and favourable source of evidence (Greenhalgh & Taylor, 1997; Ruane, 2005). Goodheart (2004) argues that "where the research evidence is spotty, we draw upon evidence from our clinical experience and expertise" (p. 4). Approaching a practicing psychoanalyst can shed light on the application of theory to practice.

Patton (2002) suggests three types of in-depth interviews – the informal conversational interview, the general interview guide approach and the standardised open-ended interview. Given the limited time (one hour) available for the interview and only one subject to be interviewed, an interview guide was chosen as the most suitable interviewing method. In preparation for this interview I worked on articulation of the



things that were puzzling for me in the research question, jotted them down and then reviewed them in sequence of priority. The interview was audio recorded and transcribed. The information obtained through the personal interview was further supplemented by several communications via email.

## **Ethical issues**

As a way of gathering data, interviewing presents ethical challenges. As Patton (2002) states, “interviews are interventions”, and “a good interview lies open thoughts, feelings, knowledge, and experience, not only to the interviewer but also to the interviewee” (p. 405). To the best of my ability I explained the aim and the nature of this study to my interviewee and ensured that he was given every opportunity to ask any questions about our email and face-to-face conversations. Before obtaining written consent I also explained that he could review and edit the parts of the dissertation where I quoted, reworded or interpreted his ideas.

In accordance with ethical guidelines issued by Auckland University of Technology Ethics Committee (AUTEC), ethical approval was obtained for the interview with Neville Symington (ethics application number 04/07).

## **Theory building**

Finally, this study utilised a modest theory building method, where findings from the systematic review and the expert interview were combined with my own thinking to further develop Bion’s (1959a) concept of ‘attacks on linking’. For Bion this concept referred to the patient’s destructive attacks on the therapist’s function to think and link one object with another. In this study I propose that the concept of ‘attacks on linking’ can be applied to therapists in thinking about their own contribution to difficult emotional experiences and the ways they deal with them.

Theory building is a valid form of research and postulates new models to guide empirical work (Turner, as cited in Appel, 1992). Turner emphasises that “theoretical cumulation is facilitated by adopting, adapting, synthesizing, stealing and developing others’ ideas” (cited in Appel, 1992, p. 252). Previously Freud (1937) wrote that “without metapsychological speculation and theorising—I had almost said

‘phantasying’—we shall not get another step forward” (p. 225). Green (1975) suggests that there is no harm in constructing a myth of origins, provided we know that it is a myth and we do not cling to our theory as the only explanation of the phenomena.

Clinical vignettes from my own work are included as illustrations of the application of the concept of the therapist’s containing capacity and attacks on linking. The use of clinical material is undertaken in compliance with the ethics approval from AUTC (ethics application number 02/33).

## **Conclusion**

This chapter has outlined the methodological approach and methods that were utilised in this study. A phenomenological interpretative paradigm with three qualitative methods was adopted in an attempt to answer the research question. The modified systematic literature review was chosen as the principal tool for gathering the evidence. The studied evidence was further supplemented and elaborated by ideas captured through an expert interview. Finally, the theory building method was applied to further develop ideas and findings gathered through the systematic review and the expert interview.

# **CHAPTER ONE: THE CONCEPT OF CONTAINMENT IN THE WORKS OF WILFRED BION AND CONTEMPORARY PSYCHOANALYSTS**

## **Introduction**

Emotional experience is central in Bion's exploration of the function of therapists' and patients' minds (Godbout, 2004). In this chapter the original concept of containment and its further development in the areas of container-contained relational variations and pathological containment in works of Bion are discussed. Next, the contemporary developments of the concept of containment are considered. Further, the dilemma of containing versus responding and the differences between containing and holding will be explored, highlighting incongruencies and misinterpretations. The chapter concludes with the critical evaluation of the concept of containment and draws a generic definition of the concept on which the rest of the study will be based.

## **The original concept of 'container-contained'**

Bion (1957/1984) initially elaborated his concept of container and contained through his work with psychotic clients. According to Symington and Symington (1996) he arrived at the idea of containing from hearing a patient say that he could not take painful experiences in. Bion (1963) suggested that "the statement that something can not be taken in must not therefore be dismissed as a mere way of speaking" (p. 6) and that it is apposite to the emotional experience. In applying his concept of containment to the mother-infant relationship Bion (1957/1984) built on the concept of projective identification introduced by Melanie Klein (1952) and its concern with the modification of infantile fears.

In Bion's view, infants become overwhelmed by extreme and unmodulated affects (like fear of death) and they project part of the psyche, namely their bad feelings, into a good breast.

Thence in due course they are removed and re-introjected. During the sojourn in the good breast they are felt to have been modified in such a way that the object that is re-introjected has become tolerable to the infant's psyche. (Bion, 1962/1984, p. 116)

Following this line of thought Bion (1962a) abstracted a model of a ‘container’ into which material is projected wherein it is ‘contained’. The attentive parent takes in these projected aspects, transforms, detoxifies, gives them meaning and returns them as more tolerable and structured experiences so the baby can assimilate them. The child eventually internalises not only transformed experiences projected into the parent but also the transforming or containing function (alpha function<sup>4</sup> in Bion’s terms) of the parent and learns to perform his own containing function.

This model was then transferred by Bion (1962a, 1963) and later psychoanalysts (Carpelan, 1989; Hamilton, 1990; LaFarge, 2000; Parment, 1994; Symington & Symington, 1996) onto the relationship between the therapist and the patient where the patient uses affect and action to evoke in the therapist an emotional experience that the patient can not bear within his own self-experience. The therapist thereby becomes a container of split-off part self-representations and object-representations for the patient (Hamilton, 1990). Like the mother does for the infant, the therapist takes in, processes and transforms those experiences to enable the patient to reintroject them safely.

Bion described what happens for the therapist in containing process thus:

I therefore assumed that I was the repository of a part of his personality such as his sanity, or the non-psychotic part of his personality....I tested the supposition that I contained the non-psychotic part of his personality, and then began to be aware that I was supposed to be conscious of what was going on while he was not. I was (contained) his ‘conscious’. Sometimes I could visualise the situation, unfolding in the analysis, as one in which the patient was a foetus to whom the mother’s emotions were communicated but to whom the stimulus for the emotions, and their source, was unknown. (1962a, p. 18)

Bion argued that the existence of containing ultimately depends upon what the recipient or therapist can bear.

When the patient strove to rid himself of fears of death which were felt to be too painful for his personality to contain, he split off his fears and put them into me, the idea apparently being that if they were allowed to repose there long enough they would undergo modification by my psyche and then could be safely reintrojected. On the occasion I have in mind the patient had felt...that I evacuated them so quickly that the feelings were not modified, but had become more painful. (1959b, p. 103)

---

<sup>4</sup> Alpha function is a mental process or working tool of a psychoanalyst that converts sense data (beta-elements) into thoughts (alpha-elements) available for further thinking and dreaming (Bion, 1962a).

The patient makes use of the therapist's containing capacity to manage affects and sensations that are like Bion's beta-elements – infantile, unmetabolised, raw sensations. The therapist containing these must struggle to tolerate the painful feelings and tremendous disturbance these elements arouse in order that he and his patient are enabled to think and talk about these elements – to turn them into Bion's alpha-elements – thoughts and dreams (Bion, 1959b, 1992; Ferro, 2005). This availability and capacity of the therapist to take in, experience and transform the unbearable increases the ability of the patient to think and bear his emotional experiences.

The analyst takes this projected part of the patient into his own emotional life, experiencing it as a pull within himself towards action, feeling and fantasy. Building upon this disturbance within himself as well as his knowledge of the patient, the analyst constructs an image of the patient's inner experience and returns this imaginatively elaborated image to the patient. (LaFarge, 2000, p. 68)

As a container, the therapist is not a passive recipient of the patient's projective identification. In his reverie and containing, the therapist reflects upon and gives meaning to the projected material; he then offers his understanding in the form of an interpretation so the patient can reintroject the now transformed aspects of himself and transform his internal self-image (Hamilton, 1990).

### **Relational variations between container and contained**

Bion conceived of the relationship between the container and contained as a dynamic one as opposed to a passive holding (Symington & Symington, 1996).

Container and contained are susceptible of conjunction and permeation by emotion. Thus conjoined or permeated or both they change in a manner usually described as growth. When disjoined or denuded of emotion they diminish in vitality, that is, approximate to inanimate objects. Both container and contained are models of abstract representations of psycho-analytic realizations. (1962a, p. 90)

Bion (1959b, 1992) distinguished three types of relationship between the container and contained – commensal, symbiotic or parasitic. Commensal relationship is where the two sides coexist and the existence of each is growth promoting (language functions as a container, used to organise and explain conscious and unconscious emotional experience). In the symbiotic relationship there is a confrontation and the result can also be growth producing (emotion is channelled by speech and speech is vitalised by

emotion). The parasitic link occurs when the object produced by the container-contained destroys both container and contained. For example, the growth promoting linking is attacked and either the emotional experience is destroyed or thinking the experience is suppressed.

According to Bion (1962a), in a growth promoting container-contained relationship development of thoughts involves the same components, container and contained, where the container is searching for the contained and the contained is seeking the container; thoughts seeking a thinker. Bion proposed that when pre-conception (a state of expectation) mates with appropriate sense impressions (particular realisation), it results in conception – thus developing a thought about emotional experience.

### **Damaged container**

Bion (1992) also developed a concept of pathologic container where, if the pleasure principle is dominant, the grimace of pain, tears or a dream of the patient can become the end-product of a mechanism that distracts from painful emotional experience via evacuating the experience into a container. For example, a patient's tears become a pathologic container of psychic pain when they do not evoke any feelings of sadness or compassion in therapist. In this instance the tears are designated to be the 'end-product' which pathologically contains the patient's pain and protects him from feeling the pain. According to Bion this happens when the evacuating patient's aim is to ensure that unwanted feelings are inescapably contained in their new receptacle (grimace of pain, tears, dream, or interpretation) and where the therapist feels he is passively to submit.

It seems to me that one might expand Bion's notion: not only the patient but also the therapist can be unable to contain certain experiences, such as anger, hostility and other feelings of which he disapproves and which can result in them being acted out, projected, denied, displaced. When the therapist is unable to contain, detoxify or digest the projected unbearable emotional experiences like envy and hate, they are not fed back to the patient in a more manageable form. Bion (cited in Ferro, 2007)<sup>5</sup> also explored the significance of psychological pain for both therapists and patients and how difficult it is to come into contact with it without defending from it by conformism and

---

<sup>5</sup> Two important writings: Italian Seminars and Brazilian Lectures by Wilfred Bion could not be accessed, thus they are referenced to those authors who reviewed these two famous writings.

general incapacity to dwell on utterance. Intolerance of the unknown and therapists' temptation to wrap themselves up in their own ideas in order to drive away disturbing and original thoughts often obstruct growth. Change can be feared and blocked not only by the patient but also by the therapist, thus Bion encouraged therapists to develop their reverie, patience and tolerance towards the unknown and the inability to make sense out of something (Bion, cited in Ferro, 2007).

Bion (1962a) suggested that the mother's capacity for reverie is essential for her to become a good container of the baby's fears where she herself does not get depressed or overwhelmed but can tune in to her baby; when the baby smiles she responds with the smile, when he gurgles she responds with similar sounds so the baby feels comforted and satisfied and his anxieties are returned in a contained form. Something similar applies to the therapist stance, that of reverie. According to Bion (cited in Symington, 1986) what this means is that the therapist should not have a theory in his mind with which he tries to make sense of what the patient is telling him, but the therapist should be prepared to be changed by his patient, to grow together with his patient. The patient relates his associations to the therapist who then, using his reverie and containment, transforms the patient's experience into alpha-elements (Boris, 1986; Lipgar & Pines, 2003). In order for the therapist to be able to employ his alpha function he needs to be in a state of reverie, which implies tolerating frustration and "listening with the third ear" (Reik, 1948).

In order to employ his reverie to full potential, the therapist should be present to the patient in every session 'without memory and desire' (Bion, 1967) in order to be aware of all aspects, regardless how familiar they might be, and stay open to what is unknown both to him and to the patient (Bion, 1967). Bion (1959b) insisted that patience in relation to suffering and frustration should be retained by the therapist without "irritable reaching after fact and reason" and that "any attempt to cling to what he knows must be resisted" (1959b, p. 124).

Few, if any, psychoanalysts should believe that they are likely to escape the feelings of persecution and depression commonly associated with the pathological states known as the paranoid-schizoid and depressive positions. In short, a sense of achievement of a correct interpretation will be commonly found to be followed almost immediately by a sense of depression. (1959b, p. 124)

## **Contemporary developments of the concept of containment**

In contemporary psychoanalytic writing, Bion's concept of container-contained plays a fundamental role in reflecting on the transference-countertransference dynamic between therapist and patient (Feinsilver, 1989; Hamilton, 1990; Lamanno-Adamo, 2006; Ogden, 2004b; Salomonsson, 1998; Vaslamatzis, 2005). For instance, Eshel (2004) describes the containing as evolving through "patient and analyst's converging, deep interconnectedness and interpenetrating impact on each other, forming a conjoint, living, therapeutic entity in which the analyst's psyche is used as an area of experiencing and transformation for the patient's expelled, unbearable experiences" (p. 323). She believes that the mutative power of containing is created by mind and heart, experiencing and thinking, reverie and holding. The process of containment seems also to be similar to what Fonagy and Target (1996) describe as the capacity for mentalisation, where in order for the child to develop a reflective ability he must have an adult thinking and imagining his thoughts and reflecting them back in an elaborated form.

### ***Container-contained relational variations***

Billow (2003) applies Bion's complex model to understand ambiguous realities of therapist-patient communication: "The container-contained represents the transformatory process of the mind reaching emotional awareness. It is a model of emotional learning that develops and is sustained in interaction with others" (2003, p. 31).

According to Billow (2003), in human development container-contained processes initially are symbiotic, based on early infant-mother projective-introjective interactions. In therapist-patient interactions symbiotic relating occurs when the therapist develops what he takes in from the patient into thought. It is about engaging with the patient's and his own feelings to emotionally process what the patient could not by himself so he can resume thinking. In commensal, more mature relating, two objects share a third to benefit all three (similar to Ogden's (1994) 'analytic third'). Emotions are valued for their informative function and words are used to contain and communicate emotion. Commensal requires achieving relative comfort with the therapist's own inner experiences and being willing to re-evoked and think about them. With this accomplished, the therapist can help the patient become more comfortable thinking and containing his own painful emotional experiences.



In parasitic relations, “one depends on another to produce a third, which is destructive of all three” (Billow, 2003, p. 40). The goal of communication here is to evade, even to destroy, meaning and meaningful emotional exchanges. The very act of thinking and searching for meaning may be hated as a process that confuses and leads to pain. Thus, frightening content can destroy a container. In the face of parasitic attacks, the therapist needs a container for his own stimulated affects. The therapeutic frame (Langs, as cited in Billow, 2003) of regulated availability, one's knowledge and training, supervision, therapeutic boundaries and contract, all may provide this essential function. The therapist's capacity to tolerate hating and being hated, while sustaining benevolence toward the patient and curiosity regarding the interaction is particularly important (Billow, 2003). By maintaining a ‘non-retaliatory disrespect’ for therapy-destructive behaviour, as well as a caring understanding, the therapist may gradually disarm parasitic communication and cultivate longed-for but distrusted symbiotic and commensal relatedness (Billow, 2003; Caper, 1997).

### *Types of the container*

A number of contemporary psychoanalysts (Herulf, 1991; Lamanno-Adamo, 2006; Miller & Twomey, 2000; Quinodoz, 1992; Symington & Symington, 1996) have identified different types of container both from the patient's and the therapist's perspectives. Quinodoz (1992), Green (1975) and Miller and Twomey (2000) write about the therapeutic setting and the frame as a container. By container they mean the therapist's creative containing capacity where the container (therapeutic contract, quiet uninterrupted listening, reflecting and interpreting) not only interacts with the contained but is mutually affected by it. For instance, patients often unconsciously attack the therapeutic container via silent resistance (Davies, 2007) or missing sessions, which, in turn pressures the therapist to abandon his creative containing capacity by either retaliatory withdrawing or not charging for the missed session.

Herulf (1991) considers therapists' integrity as a container. He argues that therapists' integrity is a prerequisite for psychotherapists to do their work as they are often the targets of not only warm and loving feelings of their patients, but also of a rough and hostile treatment, while they are supposed to provide holding and containing function. Herulf distinguishes mature and less mature types of the integrity, at the core of which is the container-contained constellation. Less mature integrity or container are oral

narcissistic integrity, where the mother's containing of the child is missing or is not good enough; and anal narcissistic integrity, characterised by autonomous control of valuable objects (mother, therapist), "kept in or expelled in accordance with an omnipotent claim to power" (p. 99). More mature integrity is phallic narcissistic integrity, characterised by possession of intrusive and nurturing as well as structuring power. The negative of this last integrity is impotence, when the therapist does not have access to his potency and analysis is not progressing. An important part of the mature integrity, according to Herulf, is a reflective attitude, which the therapist ought to have in order to work effectively with his countertransference.

Several authors see the superficial smooth therapeutic relationship as a pathological overcompliant container (Carpelan, 1985, 1989; Lamanno-Adamo, 2006; Symington & Symington, 1996). Collusion of container deficiencies of the patient and the therapist in the case of aggressive feelings leads to the emergence of the overcompliant therapeutic container, where there is no change in either the patient or the therapist. Lamanno-Adamo (2006) writes about a disturbance in a containing function of the patient, which also applies to the therapist: the 'compliant container'. Here the therapist's interventions take on the character of pseudointerpretations, not changing the structure of the unconscious fantasy but relieving the patient's anxiety, inasmuch as they allow a re-accommodation and even a concretisation of fantasies and the enmeshment of the representations of subject and object.

It is a dynamic between container and contained which is marked by an exaggerated accommodation of the contained, by excessive reasonableness, by an unrealistic harmony of connection. It relates to those analytic processes that are marked by misleading gentleness and mildness. The analysis seems to be going well, without any great conflicts manifesting themselves in the transference-countertransference field, but when we take more careful and deeper look at how it is going we find that the patient has not in fact been shaken up, has not been affected by the process at all. (Lamanno-Adamo, 2006, p. 371)

## **Containing and interpreting**

The dilemma of containing versus interpreting has been discussed in relation to effective psychotherapy practice (Bion, 1992; Ferro & Meregnani, 1997; Goodman, 1995; Green, 1998; LaFarge, 2000; Parment, 1994; Speziale-Bagliacca, 1991; Steiner, 1994; Symington & Symington, 1996). These discussions explore whether containing and responding are separate processes, whether they can exist independently or

dialectically, if one can operate without the other, whether one is more important than the other, as well as what their roles are in transformation of patients internal world and their growing ability to bear unbearable.

As already mentioned, for Bion emotional experience is at the heart of the matter and experiencing and containing are of primary importance in effective psychological change (Ogden, 2004a). Bion saw the therapist not so much as an insight provider but as a container provider (Godbout, 2004). Green (1975) wonders whether therapists can put into words the unthinkable experiences and whether the experience can be destroyed when being interpreted. Goodman (1995) understands containing as a therapist's internal process of recognising and reflecting on his affective experience, and responding as consciously shaping and articulating a countertransference feeling. Although Goodman acknowledges the need for containment, he also encourages therapists to explore their capacity for being responsive.

According to La Farge (2000) interpretation and containment are two aspects of the therapist's effort to imagine the inner world of his patient and both exist in clinical work, although one is usually dominant. La Farge suggests that the more part objects (unbearable affects) are projected into the therapist (evacuative function of projective identification), the more important part plays the containing capacity of the therapist. Whereas when the patient communicates his experience that has to do with whole objects and thus more language based communication (communicative function of projective identification), containment becomes less central and interpretation comes to the front. According to Bion (1962a) any good interpretation involves a taking in and a transformation. La Farge expands on this thought and argues that interpretation is always an act of containment.

Parment (1994) draws his attention to potential dangerous implications of choosing one over another:

The analyst has to balance sensitively, on one hand not too quickly give back to the patient the overwhelming emotions, but take time to digest them or to transform them in a way that is acceptable for the patient. On the other hand, not tolerate overly drawn-out attacks or aggressions masochistically, thereby risking being drawn into a sadomasochistic relationship or game with the patient. It is indeed a skill to be able to handle that which feels emotionally overwhelming and to wait for the right time and the right words to give to the patient. (pp. 229-230)

Speziale-Bagliacca (1991) argues that containing plays the preparatory work; only as part of a system with interpretation can the containing become a factor of transformation. Further, Steiner (1994) claims that containment is a necessary but not sufficient condition for long term development of the patient.

Although interpretation is considered to be the predominant intervention by the majority of theoreticians, containment has to be considered alongside it. Containment does not exclude the possibility of making interpretations, nor does it imply a passive attitude of waiting. It seems that the challenge is to find the balance between responding and containing.

### **Containing and holding**

Bion's (1957/1984) concept of containment and Winnicott's (1969) concept of holding are frequently confused with each other despite the fact that there are significant conceptual differences (Green, 1975; Grotstein, 1990; Ogden, 2004b; Symington & Symington, 1996). According to Ogden (2004b), Winnicott's holding is primarily concerned with being and its relationship to time, whereas Bion's container-contained is the processing (dreaming) of thoughts derived from lived emotional experience. The idea of the container-contained addresses the dynamic interaction of predominantly unconscious thoughts (the contained) and the capacity for dreaming and thinking those thoughts (the container). Ogden (2004b) stresses the dynamic, ever changing aspect of containing where container and contained coexist in an "uneasy state of mutual dependence" (p. 1359); whereas the psychological core of holding remains a constant throughout one's life.

Green (1975) and Symington and Symington (1996) emphasise the internal aspect of containing and the external aspect of holding. Symington and Symington also add that the container is not sensuous but the holding environment is. They highlight the active nature of containing, which can be either integrating or destructive, whereas the holding environment is passive and almost always positive and growth promoting. Slochower (1996) further explores the internal aspect and the active nature of containing where the therapist's capacity to contain his own subjectivity is necessary to provide a holding environment. To maintain active holding the therapist is required to never be tired, distracted, momentarily self-preoccupied – in a way disavowing his own subjectivity for too long. Slochower believes that this is not what is required from the therapist in order to contain patients' unbearable emotional experiences, but just the opposite – the

containing capacity of the therapist requires him to be in touch with his own tiredness and resentment, as well as attune to his patient's experiences. Only by putting them together will the therapist be able to successfully contain what the patient cannot and be able to interpret what is happening for the patient and himself.

While some authors provide a notion of distinction between holding and containing, some of them misunderstand the difference between the two (Cooper, 2000; Feinsilver, 1989; Kernberg, 2003). Goldberg (1989), for instance, suggests that the alienated psychotic patient requires 'active holding', which he suggests is different from 'passive containing'. Goldberg seems to understand containment as a 'passive state of empathy', and holding as an active process. Conversely, containing in Bion's theory is about doing active psychological work with the contained experiences. Therapists can misinterpret containing as the state of 'passive empathy' and so cease perusing painful internal mental creative work with their own and their patients' painful emotional experiences.

### **Critique of the concept of containing**

While different writers argue whether Bion's theory is revolutionary or not (O'Shaughnessy, 2005; Symington & Symington, 1996), his concept of containment challenges therapists to reflect on their own capacity to bear unbearable. De Bianchedi (2005) cautions therapists that often Bion's complex ideas become so socialised that they lose their capability of promoting change, become banalised and therefore not questionable or reduced to Bionian jargon. This is especially relevant to Bion's concept of containment where at times therapists talk about 'containing' something of their patients, under which they understand a variety of phenomena including containing, holding, withholding, withdrawing, enacting, resisting, etc. The language Bion used for his concept is partially responsible for that (Ferro, 2005). Bion (1962b) himself admitted that the model of container he used was not ideal, but felt that he could not find a more appropriate word.

Containment is possible when the therapist employs state of reverie - psychological work in which preconscious aspects of the mind converse with disturbing thoughts, feelings and fantasies that are precluded from conscious awareness (Ogden, 2004b). According to Bion (1959b), reverie and dreaming are the primary forms in which we do unconscious psychological work with our lived experience. Although reverie without dreaming is impossible, there is a danger that dreaming, like a cancer, can fill the

dream-space with disconnected images. Lengthy dreams can fill an entire session that are not only not utilisable for psychological work, but also undermine the potential for the therapist's reflective thinking and meaningful association (Ogden, 2004b). Where then does the boundary lie between productive reverie and defensive dissociation in the work of the therapist? It is important that therapists are conscious of not using reverie and dreaming as an excuse for not connecting to painful emotional experiences as well as be able to reflect on whether their reverie and dreaming are productive or defensive.

## Conclusion

Over the last forty years, the concept of the containment has had a profound influence with far reaching implications on the development of psychoanalytic thinking (Willoughby, 2001). Containment provides the basic model for the development of thought, for the perception of relationships and for transference and countertransference interplay. The container is not a thing and not a passive reception of what is projected, but an active process which creates an active link between therapist and patient (Vaslamatzis, 2005). "The idea of the container-contained addresses not what we think, but the way we think, that is, how we process lived experience and what occurs psychically when we are unable to do psychological work with that experience" (Ogden, 2004b, p. 1354). In this study, the containment is understood as the capacity for active internal psychological work where therapists by employing their reverie, dreaming and thinking digest their own and their patients' emotional experiences as opposed to simply discharging or evading them.

Concurrently, resistances towards this process may be mobilised to prevent experience of psychic pain. The misunderstanding of containment as a passive empathic process can block therapists from more fully connecting to their less conscious and more uncomfortable experiences. There is also a danger for the therapist to 'overdream' and become absent in those dreams for the patient. The resistances towards the repressed affects and the psychic pain arise not only in patients but also in therapists to avoid the confrontation with the truth, principally through 'attacks on the links' (Bion, 1959a) which make possible the development of thought. The following chapter will explore the therapist's contributions inhibiting his own containing capacity, expanding the concept of 'attacks on linking'.

## **CHAPTER TWO: THE THERAPIST'S CONTAINING CAPACITY AND ATTACKS ON LINKING**

### **Introduction**

This chapter discusses therapists' contributions to the diminishment of their containing capacity. Containing allows therapists to be able to think and bear difficult, often painful, emotional experiences and give them meaning so more fully conscious thinking and being can be possible (Ogden, 2004b; Parment, 1994). Through attending to their own dreaming, feeling and thinking, and use of reverie, therapists have to do psychological digesting work with their own emotions, as well as with the unbearable emotional contents projected by their patients. This capacity can be paralysed, diminished or deformed. Undertaking modest theory building, this dissertation expands the application of Bion's (1959a) concept of the 'attacks on linking', originally applied to the patient. I propose that the concept of 'the therapist's attack on linking' can be expanded to therapists' own contributions to their incapacity to bear the unbearable. These contributions include therapists' own neurosis, fear of mental pain, overidentification with the patient, desire to cure, narcissistic aspirations and their working theory; all of which will be explored as examples of therapists' attacks on their containing and linking capacity. The chapter will conclude with a clinical vignette illustrating the application of the concept of the therapist's attack on linking to reflect on the therapeutic encounter.

### **Containing, links and attack on linking in the theory of Wilfred Bion**

Closely linked with containment is the concept of basic emotional links between objects, which Bion defined as love, hate and knowledge (L, H, K) (Billow, 1999; Bion, 1962a; "Memorial meeting for Doctor Wilfred Bion", 1981). He noted that the product of the container-contained relation is meaning, which depends on the nature of the dynamic links (L, H, K) between container and contained, where emotional experiences are conceived in the relationship and are lived as a link (Willoughby, 2001). According to Bion's theory of emotional thinking, the mind can be understood by examining the various disturbances in linking (-L, -H, -K), where the therapist's containing capacity functions as a link (Vergopoulo, 1996). He employed the term 'link' to discuss "the

patient's relationship with a function rather than with the object that subserves a function" (1959a, p. 312).

In exploring how we know what we know, Bion (1962b) postulated that emotions are thoughts that are initially unmentalised and await the thinker to think them. He proposed that the therapist's containing function, alpha-function, thinking capacity and reverie mentalise thoughts. Thinking links thoughts and comes about because un-thought thoughts are too much for one to endure. Without those mental processes or links, the primary, difficult to bear emotions, can be handled via evacuation through projective identification which leads the self to get rid of the unwanted parts and be left damaged and depleted (Bion, 1959a, 1967/1984; Boris, 1986). Bion (1959a) stated that patients attack the therapist not for the content of the interpretation but for the act of interpreting, for the act implies establishing the link, a connection between two thoughts. This may then lead to the therapist implying a link or connection between people. The capacity for containing and understanding is the link which is often attacked by the patient but to protect himself from emotional experience and integration which threatens to bring mental pain (Coburn, 1998; Stern, 1989). Defending against innate tendencies to develop and integrate the basic emotions creates minus versions of the links: -L, -H, and -K (Billow, 1999; Souter, 1998). When 'minus' versions of L, H, and K proliferate, the emotions are 'hated', linkages between them are 'attacked', and hence, pre-monitory feelings<sup>6</sup> do not contribute to constructive thought and behaviour (Billow, 1999, 2000).

Bion believed that attacks against alpha-function (by envy or hate, for example) destroy the possibility of the person having contact with himself or others. The therapist is faced with a demanding task to tolerate frustration long enough to be able to digest and give meaning to his own raw sense impressions or those projected by his patients (Bion, 1967/1984; Lipgar & Pines, 2003). A capacity for tolerating frustration thus enables the psyche to develop thoughts as means by which the frustration that is tolerated is itself made more tolerable (Bion, 1962b). Incapacity for tolerating the frustration leads to its evasion by destructive attacks on capacity to link and think (Bion, 1962b). Painful in nature pre-monitory feelings often interrupt the therapist's capacity to associate and think, and intrude upon his linking capacity for reverie (LaFarge, 2000).

---

<sup>6</sup> Pre-monitory feelings is a term used by Bion (1962a) and others (see Billow, 1999) to describe raw sense impressions, primal feelings or basic emotions.



There are two main reasons that a link is not established. One is the therapist's unconscious refusal to accept the painful projections, and the other is the patient's attacks on the therapist's containing capacity (Bion, 1959a). In his original concept of the patient's attack on linking Bion focused on the patient's destructive attack on the therapist's capacity to introject the patient's projections. This is driven by patient's envy and hate of the therapist's peace of mind and the ability to process the patient's intolerable contents without disintegrating or becoming depressed (Bion, 1959a). When this happens, the creative link between two parties cannot be established and projected contents are evacuated by the therapist back into the patient rather than returned in transformed version. Creation of thought and meaning becomes impoverished (Bion, 1959a). I propose that a similar process can happen in the therapist's own mind, when his capacity to bear painful emotional experiences is diminished. In his role, a therapist will be tempted to get rid of some experiences he finds difficult to bear. The therapist can employ different manoeuvres including repression, splitting, attacks on linking (Bion, 1959a), and destruction of thought to protect himself from painful emotional experiences. Therapists' theoretical background, internal unresolved conflicts, fear of mental pain, narcissistic aspirations and over identification with patients can attack therapists' capacity to link and think. The attacking the link nature of these aspects of therapists' mental lives will be explored in more detail below.

Bion (1959a) conceptualised 'attacks on linking' as blocks in one's mind about productively bringing two or more thoughts together in a mental 'intercourse' that produces new thoughts and constitutes the ability to think. The role of the therapist is thus seen to enable the patient to establish links. Where the link is two sided – it is an intersubjective link between the therapist and the patient and it is also an internal or intrasubjective link connecting different elements in a system of signs that can be used by one's mind (Green, 1998). With the assistance of reverie or alpha-function, linking gives meaning to the emotional experience (Green, 1998). Through digesting the projected contents and connecting them with the therapist's reverie, links between unconscious experiences of the patient and of his own are created in order to understand and give meaning (Vaslamatzis, 1999, 2005).

Bion (cited in Ferro, 2007) insisted that the therapist has to concentrate all his energy on allowing the gamut of often painful transference and countertransference experiences to take place instead of hiding behind his interpretations. However, the therapist is

human and absolute integration is impossible. Thus, what is required is the ability to move between the two positions of evoking the experience and transforming the experience - paranoid-schizoid and depressive positions – to grow and learn, to reach one's anxieties, manage them and move on to the next ones (Souter, 1998).

### **The therapist's neurosis and fear of mental pain**

One of the most common blockages in the therapist's mental capacity, is the therapist's own neurosis or his unresolved conflicts that relate to his unconscious, infantile anxieties (Rosenfeld, 1987). A particular difficulty in understanding his patient arises when the projected disowned aspects of the patient correspond to aspects of the therapist that are unresolved. This may result in the therapist being unable to contain these projected parts of the patient by defensive re-projection that shuts the patient out and prevents the understanding (Cooper, 2000; Feldman, 1997; Racker, 1953; Thomson, 1980). For instance, the therapist's deficiency in self-esteem, his omnipotence, and need for reassurance put a strain on understanding of the patient's projected contents (Feldman, 1997; Symington, 1996). Money-Kyrle (cited in Feldman, 1997) suggested that the severity of the therapist's superego has a strong impact on the therapist's capacity to bear non-understanding and uncertainty, and allow himself space to have reverie. He argued that if the therapist's superego is predominantly friendly and helpful, the therapist can tolerate his own limitations without undue distress and be more open to establishing links with his patient. Therapists need to accept the idea that what is wrong with the patient might still be wrong with themselves as well (Bolognini, 1997).

Symington (1996) points out that the therapist's own narcissism can inhibit his capacity to be in the relationship with the patient to the point of obliterating his own self. He gives an example of the therapist in the session not having any feelings about the patient making a derogatory remark about the therapist's nationality. However in supervision the therapist was able to feel 'indignant' about the comment. Symington suggests that what obliterated the therapist's own sense of worth in the session was his own narcissism. The patient's own self-denigrating force was not challenged, he felt better as he had a sympathetic listener, but the core issue of his character was not addressed.

There are problems for the therapist that always remain unresolved and may not only affect the therapist's mental capacity in the relationship with the patient but also become anti-therapeutic (Rosenfeld, 1987). This can result in the tendency of the therapist to adopt particular directive roles towards his patients or to rigidly and restrictively pursue a particular line of interpretation. It is often that the fear of emotional turbulence triggers the therapist's psychopathology and his own mental pain, and he protects himself by giving a premature, stereotyped, vague or inappropriate interpretation in response not only to the patient's but also to his own anxiety, thus being unable to contain (Fleming, 2005; Grinberg, 1997; Rosenfeld, 1987).

The therapist's own neurosis is inevitably stimulated by the patient, often in automatic unthinking fashion. This is not to say the therapist is not responsible for his responses as he experiences one's own responses to the patient's influence (Racker, 1953).

Symington stresses that when therapists talk about something being projected into them there is a responsibility oneself must take if something is projected into one. He argues that therapists should take responsibility for their knowledge, and gives an example where he felt that he failed to act according to his knowledge and alienated himself from his patient (Symington, personal communication, April 4<sup>th</sup> 2007).

The therapist can feel himself in mental pain due to both his own unresolved conflicts triggered by the patient's experiences as well as due to countertransferential reactions (Fleming, 2005; Stein, 1997). According to Symington (1996), both patient and therapist will be greatly tempted to avoid mental pain. By avoiding the mental pain and avoiding the confrontation with the truth, links, which make possible the development of thought, are attacked (Mondrazak, 2004). In those instances professional supervision as well as further self-analysis work is required (Rosenfeld, 1987; Thomson, 1980; Mondrazak, 2004).

## **Overidentification with the patient**

Identification with the patient is a part of the therapist's technique to help him understand the unconscious processes of the patient. To be able to feel what the patient feels, share the unconscious fantasies and understand, the therapist has to employ trial identifications so he can feel the responses of internalised objects in the patient and understand the transference (Aaron, 1974). However, the less conscious the therapist is

about his identification, the greater the danger of overidentification with the patient (Shapiro, 1981). Feinsilver (1989) gives an example of the therapist contemplating whether he should take the flowers his patient gave him home or leave them in the office as he did not want to make his patient feel rejected nor he wanted his other patients to feel jealous. Thus the therapist strives to maintain the positive role of the protector of the relationship overidentifying with the positive objects and complying with the patient's wishes to see the negative aspects of the relationship elsewhere. Being conscious of this process is the key to treatment breakthrough; being unconscious of it can be attacking the link.

Although Freud (1915) and Reich (1951) warned therapists of their own unconscious needs and conflicts as reasons for overidentification, Feinsilver (1989) encourages therapists to be open and think about contributions from their patients to therapists' personal reactions, "particularly when these reactions seem most personal and having nothing to do with his resistant patient" (p. 441). It can be challenging to become aware of those overidentifications and one needs to learn to consider this option and look for it by asking oneself: "Does this particular strong reaction in me have anything to do with what has been going on with my patient?" (Feinsilver, 1989, p. 444).

### **The therapist's need to cure**

Caper (1992, 1995) suggests that besides the patient's pressure on the therapist to be an omnipotent healer, there is a presence in the therapist of an unconscious need to cure. Freud (cited in Caper, 1992) considered this need in the therapist to be a defence against the therapist's own unresolved sadistic and destructive impulses. "To contain the patient analytically, the analyst must first contain his anxieties about his own destructive impulses, and his omnipotent beliefs about analysis that serve as a defence against them" (Caper, 1992, p. 291).

Caper (1992) and Shaw (2003) believe that psychoanalysis and psychotherapy present therapists with emotional difficulties that trigger their unconscious narcissistic need to cure. Klein (1957/1975) argued that therapists have to acknowledge the painful reality that patients have internal destructive drives, that therapists can only help them to grow but therapists can not 'grow' them.

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 a 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. (1957/1975, p. 225)

Omnipotently healing a patient means reinforcing his attempts to split off his destructive impulses, to reassure him that he is after all a good person, and that the therapist, as the source of this reassurance, is also a good person, without ever seriously exploring the possibility that either one may not be (Caper, 1992). Only when the therapist recognises the source of his need to relieve the patient's suffering, will he be free of his need to heal the patient and will be able to produce an interpretation that simply brings together the disparate parts of the patient as it is present in the therapy situation, including the patient's unconscious role in it without "need to prod the patient into health" (Caper, 1992, p. 286).

### **The therapist's narcissistic aspirations**

Closely linked with the therapist's need to cure is his desire to be a good self-object to his patient, which can also impinge on his capacity to develop links between himself and his patient. Some authors suggest that behind this desire there are narcissistic aspirations of the therapist such as competence-seeking, grandiosity, rescue fantasy, masochistic submission, sense of loneliness, desire to be loved, desire to do useful satisfying work, and need to be needed (Shaw, 2003; Stein, 1997; Szasz, 1956). Stein (1997) suggests that the therapist striving to serve as a good self-object may represent a potential defence against the therapist's responsibility for his individuality and at times retreat to a defensive assumption, "What I am feeling could not be me; it must be the patient" (Coburn, 1998, p. 19).

Narcissistic aspirations of therapists to be good and loving can get in the way of connecting to the feelings that might contradict this image of the good therapist and become threatening to professional self-esteem (Brightman, 1985). Appearance in the therapist of troublesome feelings, like sexual attraction or hate towards his patient, can conflict with those narcissistic aspirations and can lead to the feelings staying beyond the therapist's awareness. This eventually will deprive the therapist and the patient of

connection to the unconscious processes, thus creating the treatment relationship characterised by high degree of enmeshment and affectivity.

The task is not to try and be a good and compassionate therapist for the person, because the important thing is, if you are feeling angry with someone that you allow yourself to feel it. It does not mean that you discharge it, but you actually do feel it. Because if you brush it away and say to yourself that as a psychotherapist you should not be feeling that, then you do not really engage with the patient where they are.  
(Symington, personal communication, February 2<sup>nd</sup> 2007)

What is it that drives therapists to take the position of ever-empathic therapist and avoid the negative feelings of hatred, envy or dismay? Firstly, therapists do not like feeling hatred (Epstein, 1977; Winnicott, 1951/1994). They often have an idealised image of a therapist as caring and kind and feel guilty about feeling hatred towards their patients (Epstein & Feiner, 1979). This feeling of guilt often gets in the way of therapists becoming aware of their hostile feelings towards their patients (Frederickson, 1990). Some suggest that hate troubles therapists because they want to avoid the inevitable fact that they are not devoid of feelings (Epstein, 1977), whereas others (Rosenfeld, 1987) suggest that “our discomfort derives from our wish to love our patients and our fear that if we hate, we don't love” (Frederickson, 1990, p. 495).

Secondly, the feeling of hatred or envy towards their patients can be disturbing and can resonate with the therapists' own feelings of hatred and envy. This can make the containment of those feelings difficult as the intensity of the contained can destroy the therapists' container leading to a variety of defensive mechanisms on the part of the therapist: denial, retaliatory withdrawal, acting out (Epstein & Feiner, 1979).

Thirdly, is the common misunderstanding of what it means to be an empathic therapist. Black (2004), Josephs (1998), Emde (1990) and Bolognini (1997) draw attention to theoretical incongruence and distortions of the concept of empathy. Frederickson (1990) argues that being a warm and understanding therapist is not necessarily being an empathic therapist. Warmth can represent a failure to be empathic, if the therapist responds with warmth to the patient enacting the role of his perpetrator (Frederickson, 1990). Frederickson notes that when therapists act as if they were kind and loving at the same time as their patients are mean and hateful, they create a situation where the therapist “never hates but the patient always does” (p. 491). He believes that when the

therapist allows the patient to abuse him, both the patient and the therapist are defending against the development of an intense relationship.

When the therapist has no feelings to the abuse the patient is exhibiting, the therapist becomes a repository, not a container. When I tolerated his abuse, I acted like a repository, I repeated his role as the family repository. I was not containing. Containing does not refer merely to holding feelings inside. Containment is the process by which we label those feelings and understand their meaning within the transference. As containers we are not simply passive receptacles; we are active digesters of experience.... As containers, we neither deny nor act out our feelings; we digest an initially confusing and overwhelming experience and put it into words. (Frederickson, 1990, p. 491)

Therapists suppression of angry feelings, covered by benign understanding and forbearance, can be damaging to the treatment of the patient as the more understanding the patient receives for his destructive behaviour the worse he will have to feel about himself if he were to believe in the goodness of the treatment (Epstein, 1977).

### **Therapist's working theory**

According to Green (cited in Sandler, 1993), it is generally agreed that therapists' way of thinking is determined by their training and theory, the presence of which in the consulting room (sometimes unconsciously) is unavoidable. Purcell (2004) asserts that the therapist's theory, personal and academic, is an important source of countertransference. There are significant differences between how various theories view the nature of psychopathology, the purpose of the psychoanalytic treatment and the mechanisms of change or 'cure' in psychotherapy. The therapist's theory is ever becoming an integral part of his personality and has a direct effect on clinical events by influencing the therapist's state (e.g. selective attention to clinical data), and also, more indirectly, through determining implicit qualities of his relationship with the patient. Purcell argues that a therapist's theory is a powerful organiser of his emotional experience via determining his emotional responses to the patient's behaviour. Depending on how a patient's pathology is understood in the therapist's theory, a therapist can feel either pleased or pessimistic with certain change in the client. Purcell suggests that at times consultation with a colleague adhering to a different theory can be valuable to reflect on how much the emotional experience of the therapist was organised by his working theory and thus served as a defence focusing attention away from threatening painful experiences or to rationalise defensive enactments.

Bion (cited in Ferro, 2007), Rosenfeld (1987) and Symington (1996) write that therapists may get caught up in their theories (what and how they should interpret) in order to protect themselves from threatening painful experiences. This can lead to interpreting, for example, envy all the time, or persistently interpreting the weekend in its relation to the separation anxiety (Rosenfeld, 1987), or always letting the patient start the session (Symington, 1996). Grinberg (1997) notes that the blind spots caused by the impact of the infantile in the patient on the therapist can lead to using theory as a 'blocking representation'. He suggests that the therapist's theory is necessary to enable the therapist to withstand the "regressive onslaught of the patient's projections" (1997, p. 12), but it should not be used merely to get rid of anxiety.

To avoid using theory as a defence Fleming (2005) emphasises the importance of intuition and awareness of countertransferential responses. Bion (1967) recommended a conscious state of not-knowing, a state 'without memory and desire' in order to be able to dream, contain and think about his own emotional experiences as well as those projected by his patient. "Without curiosity of mind, it is impossible that the package of theories which the psychotherapist has to rely upon is a true echo of his own inner personal self" (Symington, 1996, p. 47). Symington (1996) quotes Bion: "When you have seen a patient, instead of going and writing up the session, why not instead go and make a painting of the next session" (p. 49).

Symington gives an example when, as a beginner therapist, he used 'Freudian' or 'Kleinian' type interpretations as he had been taught 'to take up' the transference; he would make transference interpretations when he actually did not feel it. For instance, if the patient said that he felt hostile towards his brother, Symington would ask him whether he felt hostile towards him also. He suggests that "the notion that you 'should interpret transference' actually gets in the way of allowing the therapist to be and think whatever he might think" (personal communication, February 2<sup>nd</sup> 2007).



## Conclusion

### *Clinical vignette*

To conclude I will attempt to apply the concept of therapist's attack on linking, to reflect on how I contributed to the inhibitions of my containing capacity in the cited case of Miss J.

In the past interpreting Miss J's aggressiveness lead to a hostile silence and I gradually started to avoid the topic of hostility in the interpretation (-H). I also used my narcissistic self-idealisation of considering myself a 'good therapist' who provided the patient with warmth and compassion to protect myself from those fears and from thinking about it (-K). I handled my fear of her by repressing my aggression and consciously experiencing dislike of her (-H), and I covered up those thoughts with benign understanding of her struggles.

My aggressive feelings started to slip out. Miss J continuously complained that therapy made her feel worse and she was quite correct. The therapeutic relationship came to a stalemate after 20 sessions. She left feeling hate towards me for provoking her feeling of guilt for her aggressive attacks and feeling contempt for my phoney warmth (-L).

In retrospect, following Epstein (1977), I think that she could not trust my benign understanding (-L) with which I responded to her attacking behaviour as behind it was my suppressed frustration and anger at her. The more understanding she received for her destructive behaviour the worse she felt about herself. This created the danger for Miss J to see me as good and herself as bad and feel rejected by me. I, in order to like my patient, and avoid uncomfortable negative feelings (-H), tried to deny her 'badness' and make her a 'better' person, thereby turning her into an object of my fantasy and rejecting her real self (Epstein, 1977). My own unconscious attitude to anger as destructive and dangerous got in the way of my thinking that it could be useful for my patient (-K).

I also colluded with Miss J's fear of her anger, which attacked my ability to link with my patient in her anger and contain it for her so she could reintroject it in more bearable form (-K). Only in supervision could I face my own hostility and fear of its destructiveness. I connected to the fury (H) I experienced at my patient violating and

exploiting therapeutic boundaries and ignoring my existence as a separate other from which I defended myself by being emotionally unavailable and unrelated (-H, -L). I was retaliatory withdrawing (-H) but at that point I could not appreciate the hostility of my motivation (-K). This example illustrates Bion's (1959a) attacks on linking phenomena applied to the therapist where blocking thinking link (-K) leads to blocking communicative connections (-H, -L) and intimacy.

### *Summary*

In this chapter containment was discussed as depending on the nature of basic emotional links the therapist is capable of developing, not only between himself and his patient, but also between his own emotional thoughts and experiences, and those projected by his patient in order to give them meaning. When the therapist's containing capacity, which functions as a link, is attacked by either the patient or the therapist, meaning does not emerge and the pain is not suffered but avoided. The therapist's own unresolved issues and avoidance of mental pain were discussed as the therapist's own attack on emotional linking and containing of his own and his patient's unbearable experiences. The therapist can attack his linking by overidentification with the patient, fear of mental pain, needing to cure, narcissistic aspirations, having a self-image of a caring professional and his theoretical concepts. By reflecting on these the therapist can prevent or interrupt his own attacks on linking. The next chapter will discuss how the therapist can enhance his containing capacity.

## **CHAPTER THREE: ON ENHANCING THE THERAPIST'S CONTAINING CAPACITY**

### **Introduction**

Having outlined how therapists' containing capacity can be stymied, this chapter provides clinical recommendations derived from the literature on how this capacity can be developed and improved. Starting with a review of Bion's recommendations and continuing with contemporary ideas, this chapter draws on an expert interview with Neville Symington for examples and suggestions. The chapter concludes with a brief summary.

### **Bion on enhancing therapist's containing capacity**

In discussing the therapist's containing capacity Bion introduced several important concepts – reverie, faith, abandoning memory and desire, ultimate reality or truth ('O'), patience and intuition. Reverie designates the state of mind the therapist must be in to feel emotional experiences of the patient to give them shape and meaning. It represents the therapist's psychological life (ruminations, daydream, fantasies, fleeting perceptions and images that run through the mind) with the patient in the session, which should not be judged as simple inattentiveness, inexperience, fatigue, unresolved emotional conflicts or narcissistic self-involvement, but rather as a symbolic form given to the unformulated (often not yet felt) experiences of the patient (Ogden, 1997). Use of the reverie requires tolerance of the experience of being adrift and cannot be rushed to closure (Ogden, 1997; Vaslamatzis, 1999).

Reveries must be allowed to acquire meaning without analyst or analysand feeling pressured to make immediate use of them. However urgent the situation may feel, it is important that the analytic pair (at least to some degree) maintain a sense that they have 'time to waste', that there is no need to account for the 'value' of each session, each week, or each month that they spend together. (Ogden, 1997, p. 570)

Imagination is the therapist's 'instrument of understanding' (Symington, 1996). That is, through imagination therapists make emotional contact with patients and transform primal emotions into feelings and thoughts. Symington suggests that therapists need to exercise their imagination by developing a certain mental culture where they devote time to listen to music, learn art, marvel at a landscape or read poetry.

According to Bion (1959b) the therapist has to learn to bear not knowing and not understanding without “irritable reaching after fact and reason” (p. 124). Bion suggested the therapist be open to his primal feelings as an emotion receptor and analytic instrument (cited in Grotstein, 2000) via suspending his own memory, desire, understanding and preconception and keeping his inner container empty to intuit his subjective responses to the patient (Bion, 1967). “In other words, when the analyst undergoes a ‘sensory deprivation’, in effect, s/he is more open to the awareness of the operation of his/her inner sense organ from which intimations and intuitions spring forth” (Grotstein, 2000, p. 692). It is experiencing experience, in contrast to merely ‘thinking about’ or ‘reacting’ to experience, that guides learning (Billow, 1999). To suppress memory and desire can be painful and frightening, as it leaves the therapist without “a protective shell of familiar ideas” (Bion, 1967/1984, p. 150), and thus, the therapist must not be surprised to find he is himself as unwilling as his patient to abandon memory and desire.

Therapists’ intuition as a capacity to learn from the experience requires faith coupled with containing capacity. This gives rise to empathic interpretations which detoxify unbearable experiences (Davison, 2002). Intuition requires a mental space in the therapist without seeking answers but being with the emotional experience. “That sensation of not knowing, that possibility that phenomena may have no meaning, demands of me an incredible amount of tolerance to frustration” (Stitzman, 2004, p. 1152)

‘O’ or the emotional reality of the therapeutic moment is unknowable but the therapist has to open himself in the faith that he will meet it in order to be able to contain painful experiences. He needs to aim at the emotional truth of the session. It is about being and not simply knowing. Faith in ‘O’ approaches an attitude of pure receptiveness, it is an alert readiness, an alive waiting which can be uncomfortable as one must tolerate pain of fragmentation and frustration of not knowing (Eigen, 1981).

## **Other theorists on enhancing therapist's containing capacity**

### ***Preventing therapists' own neurosis from attacking the containment***

Therapists are human beings and have their own unresolved issues. However if they are aware of those issues and are able to think about them, they will be more aware of what they contribute to countertransference reactions (Steiner, 1994; Stern, 1989). Therapists have to pay attention and not ignore their emotional experiences and try to gradually understand how they relate to the patient's emerging material as well as to their own characterological make-up. This is where further personal therapy or supervision might be required to recognise blind spots and fortify judgments (Aaron, 1974; Poland, 1986; Quinodoz, 1992; Renik, 1996; Steiner, 1994; Thomson, 1980). The audacity to face the pain of the patient that reminds them of their own, requires mental courage (Symington, 1996). Audacity is possible when therapists accept limitations within themselves (Quinodoz et al, 2006).

It is difficult to distinguish influences from 'the therapist's reality' and from 'the patient's reality'. Both can attack therapist's capacity to link, think and contain. Rosenfeld writes that projective identification is often confusing to the therapist and might prevent him from thinking and interfere with his capacity for judgment and assessment of the patient. He suggests that when a pressure not to think and act is felt, it is important that "the therapist allows some time to elapse so that one can recover a power of thought and try to understand what is going on... In such a situation, even half a minute's thinking can remind one that one is a therapist" (Rosenfeld, 1987, p. 193).

### ***Working through therapists' overidentification with their patients***

According to Symington, to work through the overidentification with his patient, the therapist has to not only empathise with the fact that the patient has been badly treated but also keep wondering whether the patient was doing anything that provoked it.

For instance, when someone complains that no one seems to notice them and that people do not really seem to pay any attention to them, I might sympathise with that, but will wonder whether they somehow annihilate themselves or make their presence shut off in some way and why they do this. There is a tactic I often use as a device. When someone complaining a great deal about their husband or wife or mother, I ask them "Listen, if I had your mother here and I was talking with her, what would she say

about you?” Then you can get through to the patient without condemnation. (Symington, personal communication, February 2<sup>nd</sup> 2007)

Countertransference reactions if detected and reflected upon can make a positive contribution to the therapeutic process (Aaron, 1974). The therapist must be alert to discovering them, constantly monitoring his thoughts, feelings and impulses. Too much love, or indifference, frequent dreams about the patient, forgetting appointments, sleepiness, boredom and anxiety can be triggers for the therapist’s tool of self-awareness (Aaron, 1974). At times when the therapist’s and the patient’s internal realities and emotional experiences become enmeshed in the therapeutic dynamics, Godbout (2004) suggests that this can be helped by the therapist asking himself: What is going on here? How is the patient affecting me and how am I affecting him? What is the emotional experience here and what is being enacted?

Symington suggests that when the therapist is not aware of his feelings in the session, to afterwards ask himself whether there was something about the powerful presence of the patient that impacted on his ability to reach his own feelings. For example, when the therapist plans to tell the patient that he would be away and forgets to do this in the session, Symington encourages the therapist to think about quality of the patient’s presence and its impact on the therapist’s ability to think (personal communication, February 2<sup>nd</sup> 2007).

Similarly, Epstein (1977) suggests that to contain the hate induced by his patient, the therapist needs to observe the emotional impact the patient is having on him. He also needs to have confidence in the therapeutic value of his countertransference hate and be aware of his own counter-destructive impulses and wishes. Acknowledgement of the therapist’s fallibility as legitimate, becoming more tolerant and less ashamed of his shortcomings as well as knowing that he is bound to have countertransferential reactions allow the therapist to have greater freedom to experience those feelings, become aware of them and be able to bear and think them rather than defend against them (Stein, 1997).

### ***Developing therapists’ reverie***

In order to develop their containing capacity and reverie, therapists require curiosity, openness, an ‘act of freedom’ (Symington, 1983) and tolerance of ambiguity and uncertainty (Bion, 1967/1984). Racker (cited in Stern, 1989) suggested being as curious as possible about the patient, to be open to all the alternative formulations and one’s

reactions to the patient, to nurture and preserve these unformulated experiences. He argued that it is the attempt to escape from such feelings rather than the existence of them that gets in the way of the therapist containing the unbearable (Caper, 1992; Stern, 1989).

The analyst should permit his mind to wander all over the place, allowing himself not only to react to the patient's material but also to tolerate any thoughts or feelings that may arise. But - and this is vital - in the process of self-scanning the analyst needs to ask himself from time to time—but not all the time—why his mind has gone in this or that direction, and to reflect upon the possible countertransference implications. (Sandler, 1993, p. 1103)

Symington advises therapists to allow themselves time to think and feel. He believes that if the therapist can contain the experience, even without saying anything but recognising and observing, this by itself will have a healing effect on the patient (personal communication, February 2<sup>nd</sup> 2007). Symington encourages therapists to wait and observe their own responses to the patient's presentation. He gives an example of a patient, whose mother was killed in a car crash when he was two. Whenever the patient came to the session he would look around all the walls. Symington observed it for three years without commenting, until one day the patient himself noticed that it was the first day when he did not do it. Then Symington was able to interpret a connection between how the patient felt when he lost his mother and the mistrust he felt in the solidness of the walls (personal communication, February 2<sup>nd</sup> 2007).

Symington suggests that the therapist can be in touch with painful feelings like envy and hostility when he feels “loved as he is – with the good and the bad – love and the hatred”. He suggests that this is a personal problem of the therapist that he has to attend to in his own therapy. “It is no good trying to feel compassionate when you do not feel it. You feel what you feel. If you feel hatred then it is what you feel”. What might help the therapist to become aware of those experiences is the trust that what the hostility or envy that the patient is expressing is often not directed against the therapist. Keeping this in mind might help the therapist to be more open and accepting to his patient's painful experiences and enhance his capacity to contain them (personal communication, February 2<sup>nd</sup> 2007).

## Conclusion

In order for therapists to succeed in containing both their own and their patients' painful and difficult emotional experiences, Bion (1967) suggested they employ the attitude 'without memory and desire' in order to keep their minds open to the unknown and be more accepting and less defensive towards the unbearable experiences threatening mental pain. Other theorists, following Bion, suggest therapists allow themselves time to observe themselves and feel the experiences, to 'suffer' them in order to be able to give meaning and return them to the patient in a more bearable form. Therapists need to attend to their emotional experiences - not ignore them - in order to reflect on what in their experiences is from patients' reality and what is from their own. Those reflections will guide interventions, as well as give an opportunity to the therapist for further self-awareness growth.

To develop therapists' capacity to contain negative feelings like hatred, envy and jealousy which threaten their image of a warm caring professional, therapists need to develop confidence in the therapeutic value of those feelings, as well as attend to their own narcissistic aspirations. Reverie and imagination are of the primary significance in enhancing therapists' containing capacity, thus suspending superego and respecting the dreams, fantasies and memories from everyday life, art and nature can enrich therapists' experiences of their patients and of themselves.

Therapists' attacks on linking by their need to cure, narcissistic aspirations and their working theories represent areas for further thinking and research. In this dissertation I simply attempt to raise therapists' awareness of the impact these areas of their mental life can have on the containing capacity.



## CONCLUSION

### Clinical vignette

To conclude, I present a clinical vignette in which I demonstrate the development my capacity for containing painful emotional experiences has undergone through doing this study. Miss M, in her mid twenties, sought therapy to help her with a relationship issue. She appeared to enjoy her relationship, but felt that she was ‘missing out’ on something.

From the beginning of our first meeting I had an intense uncomfortable feeling which I could not quite grasp. I noticed being conscious of my dress, my hair, and comparing myself with Miss M and losing miserably. Miss M was stylishly dressed, with immaculate hair and make up. I then remembered how my mother used to criticise me for not wearing make up. Through the session this feeling progressively became more intense to the point of me not being able to hear what Miss M was saying. God, did I want to shake that feeling off! Facing the agony of mental pain I was tempted to attack my linking and thinking. I noticed myself about to get rid of the feeling and focus on what Miss M was saying, when I reminded myself to be patient and not to run away from pain. Godbout (2004) suggests that the best time for the therapist to stop and think about the experiences is when the experience becomes intolerable. I asked myself ‘What is this feeling and does it belong only to me?’ I did not have to wait long to really hear what Miss M was trying to communicate to me. I got it – I felt not good enough and so did she!

The feeling was intensified by my own painful feeling of not being good enough, but being able to think about the feeling made it more bearable. What I did was to allow myself to have those reveries via putting aside my harsh superego telling me that I should concentrate on what Miss M was telling me and instead asked myself – ‘Why am I feeling this right now?’ Giving myself space to think, feel what I was feeling and what I was not feeling, allowed me to connect to the feeling, to mate the preconception with conception, and for my container not to be destroyed by the contained. When I could contain the feeling and think about it, Miss M could allow herself to feel it and with a single tear claim that she had “had enough of feeling not good enough”.

## Summary

This study is a modified systematic investigation of the literature on therapists' containing capacity supplemented by an expert interview with Neville Symington to further explore application of this concept to practice. Following Bion, this study puts the emotional experience of therapists and their capacity to contain it at the heart of the matter, which demands that therapists pay attention to their emotional experiences and stay connected to them as much as they can bear. Containment is seen as the process of transformation of the patient's projected unbearable emotional experiences into tolerable and meaningful experiences by employing therapist's alpha-function, reverie, dreaming and thinking. Containing is an active mental process of developing links between the patient and the therapist and between internal conscious and unconscious experiences. It is the therapist's task to contain painful emotional experiences of his patients and to sustain his own and his patients' attacks on linking in order not to elevate or avoid mental pain but to enlarge the capacity to 'suffer' meaning. However, therapists need to be aware of the dangers of 'overdreaming' and misinterpreting containment as a passive mental process.

Bion encouraged therapists to develop their containing capacity by employing patience, faith, reverie, search for O, courage to bear mental pain and openness to the unknown. It is proposed that the therapists' containing capacity can be inhibited by therapists attacking their containing and linking capacity via their own unconscious unresolved conflicts, overidentification with their patients, desire to cure, narcissistic aspirations and their working theory. Each of the above mentioned aspects of therapists' mental life deserves further research so its relation to the therapist's containing capacity could be investigated in depth. The connection between containment and 'suffering' mental pain, where suffering means not only feeling pain but also giving meaning to the painful experience, is particularly interesting.

In order to develop their containing capacity, therapists need to allow themselves time to feel, reflect and think about their experiences in order to formulate them and make use of them in their interventions: in a way acting as their own internal supervisor encouraging themselves to stay with the feeling, feel what they feel and what they do not feel. Distinguishing what belongs to them and what belongs to their patients requires time, patience and courage to bear mental pain and to stay with the unknown.

## **What I have learned**

Through this study my own containing capacity has undergone a noticeable development. I have been motivated to reflect on my containing capacity and on the aspects of my mental life that might contribute to attacking my containing and linking capacity. As a result I am more aware of my own contributions to my reactions to my patients, as well as how I can further enhance and develop my containing capacity. I have learned to be more patient, more tolerant of uncertainties and the unknown without necessarily looking for answers or solutions. I have learned to respect my daydreams and not to push them away with harsh self-criticism of what I as a therapist should or should not be doing. I am learning to allow myself to feel the pain which in turns helps my patients to bear their own painful experiences.

If I attend to myself then the patient (or anyone else for that matter) is able to generate some healing.... The motto is *Physician heal thyself*. With a healed physician the patient can get better. (Symington, 2004, p.261)

## REFERENCES

- Aaron, R. (1974). The analyst's emotional life during work. *Journal of the American Psychoanalytic Association*, 22, 160-169.
- Appel, S. W. D. (1992). *Psychoanalysis and 'new' sociology of education: Positioning subjects*. Unpublished PhD Thesis: University of Rochester, Rochester, New York.
- Billow, R. M. (1999). LHK: The basis of emotion in Bion's theory. *Contemporary Psychoanalysis*, 35, 629-646.
- Billow, R. M. (2000). Bion's 'passion'; the analyst's pain. *Contemporary Psychoanalysis*, 36, 411-426.
- Billow, R. M. (2003). Relational variations of the 'container-contained'. *Contemporary Psychoanalysis*, 39, 27-50.
- Bion, W. R. (1962/1984). A theory of thinking. In *Second thoughts* (pp. 110-119). London: Karnac Books.
- Bion, W. R. (1957/1984). Differentiation of the psychotic from the non-psychotic personalities. In *Second thoughts* (pp. 43-64). London: Karnac Books.
- Bion, W. R. (1959a). Attacks on linking. *International Journal of Psychoanalysis*, 40, 308-315.
- Bion, W. R. (1959b). *Attention and interpretation*: Psychoanalytic Electronic Publishing.
- Bion, W. R. (1962a). *Learning from experience*: Psychoanalytic Electronic Publishing.
- Bion, W. R. (1962b). The psychoanalytic study of thinking. *International Journal of Psychoanalysis*, 43, 306-310.
- Bion, W. R. (1963). *Elements of psychoanalysis*: Psychoanalytic Electronic Publishing.
- Bion, W. R. (1967). Notes on memory and desire. *Psychoanalytic Forum*, 2, 271-280.
- Bion, W. R. (1967/1984). *Second thoughts*. London: Karnac Books.
- Bion, W. R. (1992). *Cogitations*. London: Karnac Books.
- Black, D. M. (2004). Sympathy reconfigured: Some reflections on sympathy, empathy and the discovery of values. *International Journal of Psychoanalysis*, 85, 579-596.
- Bolognini, S. (1997). Empathy and 'empathism'. *International Journal of Psychoanalysis*, 78, 279-293.
- Boris, H. N. (1986). Bion re-visited. *Contemporary Psychoanalysis*, 22, 159-184.

- Brightman, B. (1985). Narcissistic issues in the training experience of the psychotherapist. *International Journal of Psychoanalysis*, 10, 293-317.
- Caper, R. (1992). Does psychoanalysis heal? A contribution to the theory of psychoanalytic technique. *International Journal of Psychoanalysis*, 73, 283-292.
- Caper, R. (1995). On the difficulty of making a mutative interpretation. *International Journal of Psychoanalysis*, 76, 91-101.
- Caper, R. (1997). A mind of one's own. *International Journal of Psychoanalysis*, 78, 265-278.
- Carpelan, H. (1985). Container function deficiency and massive projective identification. *Scandinavian Psychoanalytic Review*, 8, 3-15.
- Carpelan, H. (1989). Reflections on Bion's container function and its pathology. *Scandinavian Psychoanalytic Review*, 12, 145-161.
- Coburn, W. J. (1998). Chapter two: Patient unconscious communication and analyst narcissistic vulnerability in the countertransference experience. *Progress in Self Psychology*, 14, 17-31.
- Cooper, S. H. (2000). Mutual containment in the psychoanalytic situation. *Psychoanalytic Dialogues*, 10, 169-194.
- Davies, A. L. (2007). *Contemplating silence*. Unpublished MHSc Dissertation, Auckland: Auckland University of Technology.
- Davison, S. (2002). Bion's perspective on the psychoanalytic method. *International Journal of Psychoanalysis*, 83, 913-917.
- De Bianchedi, T. E. (2005). Whose Bion? Who is Bion? *International Journal of Psychoanalysis*, 86, 1529-1534.
- Eigen, M. (1981). The area of faith in Winnicott, Lacan and Bion. *International Journal of Psychoanalysis*, 62, 413-433.
- Emde, R. (1990). Mobilizing fundamental modes of development: Empathic availability and therapeutic action. *Journal of the American Psychoanalytic Association*, 38, 881-913.
- Epstein, L. (1977). The therapeutic function of hate in the countertransference. *Contemporary Psychoanalysis*, 13, 442-460.
- Epstein, L., & Feiner, A. H. (1979). Countertransference: The therapist's contribution to treatment. *Contemporary Psychoanalysis*, 15, 489-513.
- Eshel, O. (2004). Let it be and become me: Notes on containing, identification and the possibility of being. *Contemporary Psychoanalysis*, 40, 323-351.
- Faimberg, H. (1992). The countertransference position and the countertransference. *International Journal of Psychoanalysis*, 73, 541-546.

- Feinsilver, D. B. (1989). Transitional relatedness, containment and the transference neurosis. *International Review of Psychoanalysis*, 16, 433-448.
- Feldman, M. (1997). Projective identification: The analyst's involvement. *International Journal of Psychoanalysis*, 78, 227-241.
- Ferro, A. (2005). Bion: Theoretical and clinical observations. *International Journal of Psychoanalysis*, 86, 1535-1542.
- Ferro, A. (2007). The Tavistock seminars; The Italian seminars by Wilfred Bion. *International Journal of Psychoanalysis*, 88(2), 551-555.
- Ferro, A., & Meregnani, A. (1997). Attacks on the analytic link: The interactive point of view. *Rivista di Psicoanalisi*, XXXIX, 43-67.
- Fleming, M. (2005). The mental pain of the psychoanalyst: A personal view. *International Forum of Psychoanalysis*, 14, 69-75.
- Fonagy, P., & Target, M. (1996). Playing with reality: Theory of mind and the normal development of psychic reality. *International Journal of Psychoanalysis*, 77, 217-233.
- Frederickson, M. S. (1990). Hate in the countertransference as an empathic position. *Contemporary Psychoanalysis*, 26, 479-495.
- Freud, S. (1910). The future prospects of psycho-analytic therapy. In *Standard Edition* (Vol. 11, pp. 139-151). London: Hogarth.
- Freud, S. (1915). The unconscious. In *Standard Edition* (Vol. 14, pp. 159-215). London: Hogarth.
- Freud, S. (1937). Analysis terminable and interminable. In *Standard Edition* (Vol. 23, pp. 209-253). London: Hogarth.
- Godbout, C. (2004). Reflections on Bion's 'elements of psychoanalysis': Experience, thought and growth. *International Journal of Psychoanalysis*, 85, 1123-1136.
- Goldberg, P. (1989). Actively seeking the holding environment - conscious and unconscious elements in the building of a therapeutic framework. *Contemporary Psychoanalysis*, 25, 448-476.
- Goodheart, C. (2004). Evidence based practice and the endeavor of psychotherapy. *The Independent Practitioner*, 24(1), 1-9.
- Goodman, A. (1995). Containing and responding. *Contemporary Psychoanalysis*, 31, 557-572.
- Green, A. (1975). The analyst, symbolization and absence in the analytic setting (On changes in analytic practice and analytic experience) - In memory of D.W. Winnicott. *International Journal of Psychoanalysis*, 56, 1-22.

- Green, A. (1998). The primordial mind and the work of the negative. *International Journal of Psychoanalysis*, 79, 649-665.
- Greenhalgh, T., & Taylor, R. (1997). How to read a paper: Papers that go beyond numbers (qualitative research). *British Medical Journal*, 315, 740-743.
- Grinberg, L. (1997). Is the transference feared by the psychoanalyst? *International Journal of Psychoanalysis*, 78, 1-14.
- Grotstein, J. S. (1990). Nothingness, meaninglessness, chaos, and the 'black hole' - The importance of nothingness, meaninglessness, and chaos in psychoanalysis. *Contemporary Psychoanalysis*, 26, 257-290.
- Grotstein, J. S. (2000). Notes on Bion's 'memory and desire'. *Journal of the American Association of Psychoanalysis*, 28, 687-694.
- Gubrium, J.F., & Holstein, J.A. (2002). *Handbook of interview research: Context and method*. London: Sage Publications.
- Hamilton, N. G. (1990). The containing function and the analyst's projective identification. *International Journal of Psychoanalysis*, 71, 445-453.
- Heimann, P. (1950). On counter-transference. *International Journal of Psychoanalysis*, 31, 81-84.
- Herulf, B. (1991). The integrity of the psychoanalyst. *Scandinavian Psychoanalytic Review*, 14, 91-105.
- Josephs, L. (1998). The mutual regulation of self-criticism. *Contemporary Psychoanalysis*, 34, 339-357.
- Kernberg, O. F. (2003). The management of affect storms in the psychoanalytic psychotherapy of borderline patients. *Journal of the American Psychoanalytic Association*, 51, 517-544.
- Klein, M. (1952). *The writings of Melanie Klein* (Vol. 3). London: Hogarth.
- Klein, M. (1957/1975). Envy and gratitude. In M.M.R. Khan (Ed), *Envy and gratitude and other works 1946-1963* (Vol. 104, pp.176-236): International Psychoanalytic Library.
- LaFarge, L. (2000). Interpretation and containment. *International Journal of Psychoanalysis*, 81, 67-84.
- Lamanno-Adamo, V. L. C. (2006). Aspects of a compliant container: Considering narcissistic personality configurations. *International Journal of Psychoanalysis*, 87, 369-382.
- Lipgar, R. M., & Pines, M. (2003). *Building on Bion: Branches. Contemporary developments and applications of Bion's contributions to theory and practice*. London and New York: Jessica Kinsley.

- Maldonado, J. L. (2003). Obstacles facing the psychoanalyst when interpreting narcissistic pathologies: Characteristics of the authoritarian patient. *International Journal of Psychoanalysis*, 84, 347-366.
- Memorial meeting for Doctor Wilfred Bion. (1981). *International Review of Psychoanalysis*, 8, 3-14.
- Miller, L., & Twomey, J. E. (2000). Incoherence incognito: The collapse of the third in a fee-for-service structure. *Contemporary Psychoanalysis*, 36, 427-456.
- Milton, M. (2002). Evidence-based practice: issues for psychotherapy. *Psychoanalytic Psychotherapy*, 16(2), 160-172.
- Mondrazak, V. S. (2004). Psychoanalytic process and thought: Convergence of Bion and Matte-Blanco. *International Journal of Psychoanalysis*, 85, 597-614.
- Najavits, L. M. (2000). Researching therapist emotions and countertransference. *Cognitive and Behavioral Practice*, 7, 322-328.
- O'Shaughnessy, E. (2005). Whose Bion? *International Journal of Psychoanalysis*, 86, 1523-1528.
- Ogden, T.H. (1994). The analytic third - working with intersubjective clinical facts. *International Journal of Psychoanalysis*, 75, 3-20.
- Ogden, T. H. (1997). Reverie and interpretation: Henry James. *Psychoanalytic Quarterly*, 66, 567-595.
- Ogden, T. H. (2004a). An introduction to the reading of Bion. *International Journal of Psychoanalysis*, 85, 285-300.
- Ogden, T. H. (2004b). On holding and containing, being and dreaming. *International Journal of Psychoanalysis*, 85, 1349-1364.
- Parment, U. B. (1994). Interaction and interpretation: "How can I tell what I think till I see what I say?" *International Forum of Psychoanalysis*, 3, 227-232.
- Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3<sup>rd</sup> ed.). Thousand Oaks: Sage.
- Petticrew, M., & Roberts, H. (2006). *Systematic reviews in the social science. A practical guide*. Cornwall, UK: Blackwell Publishing.
- Poland, W. S. (1986). The analyst's words. *Psychoanalytic Quarterly*, 55, 244-272.
- Pope, K. S., & Tabachnick, B. G. (1993). Therapist's anger, hate, fear, and sexual feelings: National survey of therapist's responses, client characteristics, critical events, formal complaints, and training. *Professional Psychology: Research and Practice*, 24(2), 142-152.



- Purcell, S. D. (2004). The analyst's theory: A third source of countertransference. *International Journal of Psychoanalysis*, 85, 635-652.
- Quinodoz, D. (1992). The psychoanalytic setting as the instrument of the container function. *International Journal of Psychoanalysis*, 73, 627-635.
- Quinodoz, D., Aubry, C., Bonard, O., Dejussel, G., & Reith, B. (2006). Being a psychoanalyst: An everyday audacity. *International Journal of Psychoanalysis*, 87, 329-347.
- Racker, H. (1953). A contribution to the problem of counter-transference. *International Journal of Psychoanalysis*, 34, 313-324.
- Reich, A. (1951). On counter-transference. *International Journal of Psychoanalysis*, 32, 25-31.
- Reik, T. (1948). *Listening with the third ear: The inner experience of psychoanalysis*. New York: Noonday.
- Renik, O. (1996). The analyst's self-discovery. *Psychoanalytic Inquiry*, 16, 390-400.
- Rosenfeld, H. (1987). *Impasse and interpretation*. London and New York: Tavistock.
- Ruane, J. M. (2005). *Essentials of research methods*. Cornwall, UK: Blackwell.
- Salomonsson, B. (1998). Between listening and expression: On desire, resonance and containment. *Scandinavian Psychoanalytic Review*, 21, 168-182.
- Sandler, J. (1993). On communication from patient to analyst: Not everything is projective identification. *International Journal of Psychoanalysis*, 74, 1097-1107.
- Shapiro, T. (1981). Empathy: A critical reevaluation. *Psychoanalytic Inquiry*, 1, 423-448.
- Shaw, D. (2003). On the therapeutic action of analytic love. *Contemporary Psychoanalysis*, 39, 251-278.
- Slochower, J. (1996). Holding and the fate of the analyst's subjectivity. *Psychoanalytic Dialogues*, 6, 323-353.
- Souter, K. T. (1998). *Attacks on links in the work of Samuel Beckett and Wilfred Bion*. Paper presented at the MLA Conference, San Francisco, USA.
- Speziale-Bagliacca, R. (1991). The capacity to contain: Notes on its function in psychic change. *International Journal of Psychoanalysis*, 72, 27-33.
- Stein, R. (1997). The shame experiences of the analyst. *Progress in Self Psychology*, 13, 109-123.

- Steiner, J. (1994). Patient-centred and analyst-centred interpretations: Some implications of containment and countertransference. *Psychoanalytic Inquiry*, 14, 406-422.
- Stern, D. B. (1989). The analyst's unformulated experience of the patient. *Contemporary Psychoanalysis*, 25, 1-33.
- Stitzman, L. (2004). At-one-ment, intuition and 'suchness'. *International Journal of Psychoanalysis*, 85, 1137-1155.
- Symington, J., & Symington, N. (1996). *The clinical thinking of Wilfred Bion*. London: Routledge.
- Symington, N. (1983). The analyst's act of freedom as agent of therapeutic change. *International Review of Psychoanalysis*, 10, 283-291.
- Symington, N. (1986). *The analytic experience: Lectures from Tavistock* London: Free Association.
- Symington, N. (1996). *The making of a psychotherapist*. London: Karnac.
- Symington, N. (2004). Two sessions with Lawrence. *International Journal of Psychoanalysis*, 85, 253-268.
- Szasz, T., S. (1956). On the experiences of the psychoanalyst in the psychoanalytic situation. *Journal of the American Psychoanalytic Association*, 4, 197-223.
- Thomson, P. G. (1980). On the receptive function of the analyst. *International Review of Psychoanalysis*, 7, 183-205.
- Vaslamatzis, G. (1999). On the therapist's reverie and containing function. *Psychoanalytic Quarterly*, 68, 431-440.
- Vaslamatzis, G. (2005). Projective identification, containment and sojourn in the psyche: Clinical notes on a specific type of transference-countertransference interaction. *International Forum of Psychoanalysis*, 14, 116-119.
- Vergopoulo, T. (1996). Panel report: Bion's contribution to psychoanalytic theory and technique: Chaired by Leon Grinberg. *International Journal of Psychoanalysis*, 77, 575-577.
- Willoughby, R. (2001). 'The Dungeon of Thyself': The claustrum as pathological container. *International Journal of Psychoanalysis*, 82, 917-931.
- Winnicott, D. (1951/1994). Hate in the countertransference. *Journal of Psychotherapy Practice and Research*, 3, 350-356.
- Winnicott, D. (1969). The use of an object. *International Journal of Psychoanalysis*, 50, 711-716.

## Appendix A

As the focus of this study is to explore a psychoanalytic concept introduced by Wilfred Bion, Psychoanalytic Electronic Publishing (PEP) database was chosen as the primary source of literature. PEP contains full text articles from ten leading psychoanalytic journals for the period 1920-2003 and individual journals are available including 2007.

A preliminary literature search was based on a free associated brainstormed list of search word combinations represented in the table below.

Search term	Number of articles	Relevant articles with exclusion criteria
Bearing unbearable (paragraph)	9	2
Analyst's negative countertransference (paragraph)	59	4
Analyst's unconscious processes (paragraph)	98	7
Analyst's emotional experiences (paragraph)	86	4
Analyst working with anger (paragraph)	21	2
Analyst allowing feelings (paragraph)	32	2

The criterion of relevance was selection of those articles and books containing therapists' critical evaluation of their ways of dealing with difficult emotional experiences towards their clients and themselves. In addition, to the literature search, I also used articles and books suggested by my supervisor, as well as discussions centering on painful experiences in practice, with my supervisor and Neville Symington.

As the literature obtained through the preliminary search was reviewed, I further refined and systemised my search to include the following keywords presented in the following table:

Search term	Number of articles	Relevant articles with exclusion criteria
Containment (title)	14	9
Container (title)	10	10
Containing (title)	15	11
Containing capacity (paragraph)	148	29
Analyst's containing capacity (paragraph)	16	6
Analyst container and contained (paragraph)	55	16
Types of container	10	5

In addition to this search, reference lists from the relevant articles and identified additional readings were reviewed. The second search resulted in a large number of articles, most of which either mentioned “containing” as a word to convey “to hold” or “to bear” something, or addressed the client’s difficulty in containing their emotional experiences, rather than in its conceptual meaning. The readings selected for the literature review dealt primarily with therapists’ difficulties in containing difficult/painful emotional experiences, as well as the readings that treated the phenomena of containing in its original Bion’s conceptual meaning.

Readings and papers that were not published, were not in English, or were on child, adolescence, couple or group psychotherapy were excluded from the search. Although the concept of container-contained was applied to the analysis of group dynamics both by Bion and his followers, I felt it was important to focus on one-one-one therapeutic encounters as group therapy might contain other variables impacting on container-contained dynamics, thus representing a separate research issue.