12 *Expressive uses of the countertransference: notes to the patient from oneself*

LIKE many clinicians these days I believe that for differing reasons and in varied ways analysands re-create their infantile life in the transference in such a determined and unconsciously accomplished way that the analyst is compelled to relive elements of this infantile history through his countertransference, his internal response to the analysand. Patients may enact fragments of a parent, inviting us unconsciously to learn through experience how it felt to be the child of such a parent and, ironically, they may almost violently exaggerate the child they had been in the transference, tentatively looking to see if we become the mad parent.

In this chapter I will not focus, however, on how we organize our countertransference experience into object-relational and genetic perspectives. I believe we are almost too eager to translate our experience into analytic frames of reference. Indeed, if what we refer to by the concept of countertransference is not to lose its integrity, then we must acknowledge more frankly that in the midst of countertransference experiencing the analyst may for a very long time indeed exist in an unknowable region. To be sure, he may know that he is being cumulatively coerced by the patient's transference towards some interpersonal environment, but analyses rarely proceed with such clarity that the clinician knows in **statu nascendi** what and whom he is meant to become. That his internal life is the object of the analysand's intersubjective claim is known, however, to analyst and patient alike. Disturbed patients, or analysands in very distressed states of mind, know they are disturbing the analyst. Indeed it is as if they need to place their stress in the analyst.

I think it is crucial that the clinician should find a way to make his subjective states of mind available to the patient and to himself as objects of the analysis even when he does not yet know what these states mean. I also believe that on rare but significant occasions the analyst may analyse his experience as the object of the patient's transference in the presence of the patient (Tauber, 1954; Little, 1981; Ehrenberg, 1984; Coltart, 1986; Symington, 1983).

COUNTERTRANSFERENCE READINESS

Alongside the analyst's 'freely and evenly hovering attention which enables the analyst to listen simultaneously on many levels,' writes Paula Heimann, 'he needs a freely roused emotional sensibility so as to perceive and follow closely his patient's emotional movements and unconscious phantasies' (1960, p. 10). If the analyst regards the emergence within himself of feelings, phantasies, passingly inappropriate and withheld interpretations, and inarticulate senses about the patient, as disturbing his evenly hovering attention or upsetting his neutrality, then, from Heimann's point of view, the analyst ironically would terminate an analytic relation to the patient's unconscious life. No less a person than the founder of psychoanalysis said that the analyst 'must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient' (Freud, 1912, p. 115).

The psychoanalyst's establishment of mental neutrality is akin, in my view, to the creation of an internal potential space (Winnicott, 1974), that functions as a frame (Milner, 1952) through which the patient can live an infantile life anew without the troublesome impingement of the clinician's judgements. The psychoanalyst's neutrality functions as a dream screen (Lewin, 1946): it is there, but only as an area within the analyst which registers non-neutral feelings, phantasies and thoughts, just as the dream differs from that internal screen that bears it.

By cultivating a freely-roused emotional sensibility, the analyst welcomes news from within himself that is reported through his own intuitions, feelings, passing images, phantasies and imagined interpretive interventions. It is a feature of our present-day understanding of the transference that the other source of

the analysand's free association is the psychoanalyst's countertransference, so much so that in order to find the patient we must look for him within ourselves. This process inevitably points to the fact that there are two 'patients' within the session and therefore two complementary sources of free association.

ANALYST AS PATIENT TO HIMSELF

It is in keeping with the spirit of psychoanalysis, as that discipline which uses human interaction to discover the nature of the patient's unconscious life, for the analyst to approach himself in a session as the other patient, which he can accomplish by facilitating his own internal mental processes that complement the patient's free associations.

By establishing a countertransference readiness I am creating an internal space which allows for a more complete and articulate expression of the patient's transference speech than if I were to close down this internal space and replace it with some ideal notion of absolute mental neutrality or scientific detachment. (I explore this further in the next chapter.) Indeed, by maintaining an internal space for the reception of the patient's transference, the analyst is more likely to fulfil the intention of Freud's concept of the analyst's mirror function.[8]

What the analyst feels, imagines and thinks to himself while with the patient may at any one moment be a specific element of the patient's projectively-identified psychic life. I prefer, however, to use Giovacchini's (1979) concept of externalization to classify that creation of a total environment in which both patient and analyst pursue a 'life' together.

Patients create environments. Each environment is idiomatic and therefore unique. The analyst is invited to fulfil differing and changing object representations in the environment, but such observations on our part are the rare moments of clarity in the countertransference. For a very long period of time, and perhaps it never ends, we are being taken into the patient's environmental idiom, and for considerable stretches of time we do not know who we are, what function we are meant to fulfil, or our fate as his object. Neither do we always know whether what we might call our existence is due to that which is projected into us or whether we are having our own idiomatic responses to life within the patient's environment. This inevitable, ever-present, and necessary uncertainty about why we feel as we do gives to our private ongoing consideration of the countertransference a certain humility and responsibility.

The most ordinary countertransference state is a not-knowing-yet-experiencing one. I know that I am in the process of experiencing something, but I do not as yet know what it is, and I may have to sustain this not knowing for a long time. I do not mean that I am unaware of discrete affects and thoughts while with a patient – of course, such mental life continues and is clear up to a point. Nevertheless, I find that to see where I am, what I am, who I am, how I am meant to function and in what psychodevelopmental time of the patient I live takes months and years to discover. The capacity to bear and value this necessary uncertainty defines one of our most important clinical responsibilities to the patient; and it enhances our ability to become lost inside the patient's evolving environment, enabling the patient to manipulate us through transference usage into object identity. If our own sense of identity is certain, then its loss within the clinical space is essential to the patient's discovery of himself.

I think the analyst is more able to achieve that necessary process of drawing an identity together, which allows him to receive and register the patient's transferences, if he can tolerate the necessary loss of his personal sense of identity within the clinical situation. By permitting himself to be used as an object (Winnicott, 1968), the analyst is part of a process that facilitates the eventual cohesion of the analysand's sense of self, but in order for this procedure to work it is my view that the analyst must maximize his countertransference readiness, listening to the patient who is using him. Object usage can be discovered through the effect of the use. To answer the question 'how does a patient at a preoedipal level employ us?', we must turn to the countertransference and ask of ourself, 'how do we feel used?'.

More often than not we are made use of through our affects,

through the patient generating the required feeling within us. In many ways this is precisely how a baby 'speaks' to its mother. The baby evokes a feeling-perception in the mother that either inspires some action in her on the baby's behalf or leads her to put the baby's object usage into language, engaging the infant in the journey towards verbal representation of internal psychic states. The infant element in the adult patient speaks to the analyst through that sort of object usage that is best 'seen' through the analyst's countertransference. The infant within the adult person cannot find a voice, however, unless the clinician allows the patient to affect him, and this inevitably means that the analyst must become disturbed by the patient.

If an analyst is well analysed and possesses confidence in his own ego functioning and object relatedness then I think it is more likely that he will have the necessary capacity for generative countertransference regression (see below, chapter 14) within the session. We know that the analytic space and process facilitate regressive elements in analyst as well as in patient, so each analyst working with, rather than against, the countertransference must be prepared on occasion to become situationally ill. His receptivity to the reliving of the patient's transference will inevitably mean that the patient's representation of disturbed bits of the mother, father or infant self will be experienced in the transference usage of the analyst.

Like most analysts working with quite disturbed patients, I have evolved a kind of generative split in my own analytic ego. I am receptive to varying degrees of 'madness' in myself occasioned by life in the patient's environment. In another area of myself, however, I am constantly there as an analyst, observing, assessing and holding that part of me that is necessarily ill.

In moments such as these who is the patient? In my view, much of the work of analysis will have to take place within the analyst (Feiner, 1979), since it is the analyst who, through his situational illness, is the patient in greatest need. Indeed, in order to facilitate the analysand's cure, the analyst will often have occasion to treat his own situational illness first. To be sure, in treating myself I am also attending to the patient, for my own disturbance in some way reflects the patient's transference. Thus in turning to myself as that other patient, I am cognizant that I may be analysing something of the patient's mother or father, or some aspect of the patient's mind which he finds unbearable.

THE ANALYST'S USE OF THE SUBJECTIVE

Because the analyst is the other patient, sustaining in himself some intersubjective discourse with the analysand, it is essential to find some way to put forward for analytic investigation that which is occurring in the analyst as a purely subjective and private experience. It is essential to do this because in many patients the free associative process takes place within the analyst, and the clinician must find some way to report his internal processes to link the patient with something that he has lost in himself and enable him to engage more authentically with the free associative process.

One difficulty is how to make material available to the patient when the analyst may not as yet know the unconscious meaning. Were the analyst to wait until that time when he knew what the patient was communicating to him through the transference, it might well be months before he could speak. More likely, because he restricted his interpretation to that which he knew, the unconscious meaning might be lost.

The analyst must be prepared to be subjective in selected ways in the presence of the patient in order for the patient to use his own nascent subjective states. How does one do this? To some very considerable extent it is a question of the analyst's relation to his own feelings and thoughts. I think it is quite possible to be firm and interpretively vigorous without translating the patient to himself, unless such translation is put to the patient as an idea emerging from the analyst's subjectivity, rather than from his authority. As Winnicott said (1971), the analyst needs to play with the patient, to put forth an idea as an object that exists in that potential space between the patient and the analyst, an object that is meant to be passed back and forth between the two and, if it turns out to be of use to the patient, it will be stored away as that sort of objective object that has withstood a certain

scrutiny. Any examination of Winnicott's clinical case presentations reveals a person who certainly worked in a highly idiomatic way, and yet he concerns himself in his clinical theory with the unintrusive function of the analyst, with the analyst as a facilitating environment. How is it possible to be so idiomatic in one's presentation of interpretations and not be traumatic to the patient? In my view, the answer lies in the way Winnicott regarded his own thoughts: they were for him subjective objects, and he put them to the patient as objects between patient and analyst rather than as official psychoanalytic decodings of the person's unconscious life. The effect of his attitude is crucial, as his interpretations were meant to be played with – kicked around, mulled over, torn to pieces – rather than regarded as the official version of the truth.

If the psychoanalyst has a particular kind of relation to his own interpretations as possible truth-bearing objects, and so possesses a capacity to release the patient for new self experiences, then it is possible to disclose his subjective states of mind to the analysand. The aim of releasing the subjective state of mind into play is to reach the patient and provide him with a scrap of material that facilitates the cumulative elaboration of his own internal states of being.

Like many an analyst I announce the subjective factor by saying 'what occurs to me', 'I am thinking that', 'I have an idea', or something of that kind. If I know that my interpretation is going to be somewhat upsetting to a patient, I may say, 'now I don't think you are going to like what occurs to me but,' and proceed to put forth my thought, or, if that which is going on in me is significantly out of context with the manifest content of what the patient is discussing, I might say, 'this may sound quite mad to you but,' and proceed to state what I think. Inevitably, I strive to put my thoughts to the patient in such a way that he does not feel himself to be cornered or given an official version of the psychoanalytic truth.

The analyst's use of his own subjectivity, which admittedly is only part of the total interpretive picture, increases the patient's trust in the value of seemingly unsupported statements. If such

interpreting is developed by the analyst responsibly and judiciously, the analysis is enhanced because the analyst is able to release certain countertransference states for elaboration, and in so doing, he makes certain split-off elements of the patient available for knowing and analysing. Since so much of the psychic life in the clinical setting is within the analyst, one of our emerging technical difficulties is how either to give back to the patient what he has lost or bring to his attention those parts of himself that he may never have known.

SELF RELATING IN THE ANALYST

Each one of us is perpetually engaged in a complex relationship to the self as an object (see above, chapter 3), and the analyst demonstrates his own form of self relating in the way he perceives and relates to his own interpretations in the presence of the patient. For example, when in the midst of an interpretation to a patient I may suddenly realize that I am slightly off base, and I will stop myself and say something like 'nope, that's not it, I can't quite find what I want to say'. If I realize that I am wrong, I will say so and state something like, 'no, I think what I have just said, as plausible as it is, is just not right'. I am well aware that I live out a form of self relating in the presence of the patient, with one part of me functioning as the source of material – like the patient in the analysis – and another part of me functioning as the analyst. I do this because I think it is very difficult to put into words what I believe a patient's mood to be. This open struggle to put forth verbal articulations of one's own subjective states is an important feature of my technique, especially with the more severely disturbed patient, for, in my view, I am gradually putting out into that potential space between us those associations that are moving freely within me but are occasioned by the patient, and I am making it possible for the patient to engage meaningfully in this struggle. Time and time again when I am working to describe the non-verbal transference, the patient will join in and use his or her own verbal representations to speak elements of himself. Furthermore, of course, part of the analysand's total recognition of this process is his being found

through the analyst's registration of him, which the patient gradually values as another feature of the psychoanalytic process.

This selective and occasional verbalization of my own subjective sense of the patient's mood or intent is a vital cumulative prerequisite for that relatively rare moment when I make a direct use of the countertransference. In verbalizing my own subjective states I am, of course, making aspects of my countertransference available for mutual scrutiny within the session, and over time I enable the patient to use such interventions as important sources of material.

SENSING

The gradual non-traumatic use of my own subjectivity is an essential element in my work especially with severely disturbed patients. As I am particularly concerned to work with the emotional core of the patient in each session, it is important to be able to signify what, amidst the patient's associations, seems to announce true self activity. By true self activity I mean that which seems to work from the core of the self outward as a spontaneous gesture.

I am here referring to those sorts of feelings an analyst has in working with a patient which can be described as intuitions, or more accurately as senses. By saying to a patient, 'you know, I really don't know whether what I am going to say is true, but I have a feeling that . . .', or 'I sense you have moved away from the completion of a feeling; you seem to be saying . . .', I am endeavouring to establish a neutral vocabulary for the identification of the analysand's affects and nascent ego developments which can, in my view, only be reached if the analyst can work from intuitive sensing. I have often found that when I say to a patient that it is my sense that x is true or that he has avoided y (x and y being words that struggle to express an unknown but present state of mood or mind), such communications have proved to be important facilitators, so the patient can complete the developing feeling, thought or ego capacity which had been lost, discarded, or perhaps unappreciated by him up until that point.

It is my view that this kind of therapeutic intervention constitutes an indirect use of the countertransference. The analyst uses his relation to himself as an object to put his own subjective state into words, and he may very well be speaking up for x (for what it means) before he knows what x is. That is, the analyst does not consciously understand what the patient means, but he has a sense of a meaning that is present and which requires his support in order to find its way towards articulation and the all-important task of analysis. Such an intervention is obviously more suitable to those self states in a patient that may be non-verbal or pre-verbal, and for some time the analyst may need to 'pick up' and 'work with' his own affects and subjective states, all the while functioning visibly as transformational object to himself, engaged in the task of developing the unspoken for towards meaningful and sentient verbal articulation. Obviously in so doing, the analyst takes on the historical-existential trace of the mother's function in relation to the infant, seeking out and relating to the patient's unconscious gestures or infant speech.

A baby may make a sound or create a spontaneous gesture that is mirrored and transformed by the mother's own verbalization of the phenomenon. She might say 'ooooh' or 'mmmmmm' and her articulation is somewhere between sound as gesture itself and symbolic communication in the adult manner. In some ways, when the analyst speaks up for a subjective state in himself, he does so in order to reflect an infant element in the patient and to transform this element by putting it into some kind of speech.

By finding a way to do this with a patient, I am deeply aware that I am now able to work with an analysand from my own sense of conviction about what is true, rather than solely as the interpreter of unconscious themes. It is my experience that patients benefit from the analyst's responsible and comfortable rootedness in subjective experience. The assessment of that which is true in the patient springs not inevitably from the rather over-intellectualized cullings of unconscious themes as read by both patient and analyst, but instead from a mutual sense of having touched upon a detail in the session that gives both analyst and

analysand a sense of appropriate conviction that the patient's true self has been found and registered.

FROM INDIRECT TO DIRECT USE OF COUNTERTRANSFERENCE

By now it should be clear how I make an indirect use of my countertransference, by putting verbal representations of my subjective states of mind to my patient for consideration. In so doing, I establish my subjectivity as a useful and consistent source of material in the psychoanalytic situation. This constitutes an other source of freely associated material. As long as the analyst is judicious and clinically responsible, then the use of such self observations in the presence of the patient will enable the analysand to develop increased trust in the value of expressing as yet unknowable subjective states. Ultimately, of course, the aim of this indirect use of the countertransference is to facilitate the articulation of heretofore inarticulate elements of psychic life, or what I term the unthought known. Once the patient's self state is verbally represented, then it can be analysed.

By direct use of the countertransference I mean that quite rare occasion, one which may be of exceptional value to the effectiveness of the analysis, when the analyst describes his experience as the object. To be sure, there may be moments when it is difficult to distinguish between the indirect and the direct use of the countertransference, as, for example, when a patient is so persecutory or unreachable that the analyst's expressed observation of his own feeling state or state of self is somewhere in between expressing the sense of the situation and declaring how he feels as the object of the patient's transference. In such a case, communicating what the analyst senses about the patient in the session is an indirect use of the countertransference, and describing how he feels about being her object is a direct use.

Before I proceed to illustrate my thinking with clinical examples, I must stress that I am not at any point here, in relation to either an indirect or a direct use of the countertransference, referring to the clinician's thoughtless discharge of affect. As in any analytic intervention, it is exceedingly important to consider whether the patient can use an intervention, and this is why I place so much emphasis on the gradual presentation over time of the analyst's sense of the situation, as a prerequisite to any direct expression of the countertransference. Any disclosure on the analyst's part of how he feels must be experienced by the patient as a legitimate and natural part of the analytic process. If it comes as a shock, then the analyst has failed in his technique. Finally, however much it might relieve the analyst to describe his state of mind to a patient, such an action should never be undertaken solely for the purpose of the analyst's self cure. There are some patients to whom one could not ever usefully express one's experience as their object, and this must be accepted.

CLINICAL EXAMPLES / I

I found myself in a curious position when Helen, a woman in her mid-twenties, started her analysis. She would begin to describe a situation, such as going to meet a friend, and then she would stop her account in mid-sentence. She would pause for a long time, often as much as several minutes, and then she would resume her account as if there had been no interruption. Initially I focused, as I always do with someone new to analysis with me, on how difficult it was to speak to a stranger and how hard it was to entrust the simplest things to him. Her anxiety about being in the analytic situation was very apparent, and this interpretation of the transference was necessary and to some degree accurate. But nevertheless, her long pauses continued, and I knew I had not fully understood the situation. It was not due simply to initial anxiety in the transference, of the sort: 'Who is this man, and how do I talk to him?'.

I knew that several years earlier she had had a spell of psychotherapy with a psychoanalyst who was exceedingly interpretive. She told me that she was accustomed to saying just a bit about something, and the analyst would translate her fragment into a full interpretation about some aspect of her relation to him. I therefore considered it a possibility that she paused because she was waiting for me to translate her through a particular type of

interpretation, and so I said I thought she was waiting for me to intervene like her previous analyst. She agreed with this, and for some time I thought that perhaps this was the crux of the matter. I rather expected her to get on with telling me about herself without such disconcerting pauses.

No such luck. Instead I found the situation quite unchanged, so I knew that this feature of her character was much deeper than I had reckoned; it was not just either a situational reaction to myself or a residual reaction to her previous analyst. As I realized this, I knew I would have to settle into this situation and accept it as the sort of environment she creates in which both she and her objects live. Increasingly I asked myself how I felt as an object of such a transference.

I knew that I felt irritated on occasions, but equally I felt there was no way in which to utilize this irritation for some kind of alteration of the environment. As it was very difficult for me to follow her line of thinking, because of the many interruptions and long pauses, I was aware of being confused by her. I found as the months passed that I would 'wander off' during these pauses, and when she would resume talking it might be a few seconds before I had returned to listen. My sense of her as a person was also changing. I was aware of thinking of her less as a person with a life to live and to tell me about than as a kind of opaque and diffuse presence. I did not think of her as helpful in the way that patients commonly assist the analyst to consider them. Instead, knowing in advance how the sessions would go, I began to feel bored and sleepy.

To be sure, I took internal measures against sleepiness in the countertransference. I thought a lot about what this might all mean within the transference-countertransference idiom, and I entertained the idea that she might be transferring to the analytic situation the nature of her mother's idiom of maternal care, and that I – the infant-object of such a care system – was an existential witness to a very strange and absent mother. I decided that the material expressive of the patient's mental life was now in me, insofar as my countertransference began to dominate the clinical situation, at least in my mind. I knew I would have to find some way to make the material available to her. After several months of analysis, when I thought the patient was ready to receive an indirect expression of my countertransference, I told her that I was aware of something taking place in me that I thought was of interest, and I wanted to put it to her for reflection and ultimately for analysis. I proceeded to tell her that her long pauses left me in a curious state, one in which I sometimes lost track of her, and it seemed to me that she was creating some kind of absence that I was meant to experience. A bit later in the session I said to her that she seemed to disappear and reappear without announcement of either action.

The patient was immediately relieved when I spoke up for my own subjective state. She said that she had long known about this habit, but did not understand it herself, since it was not occasioned by anxiety, and that she would often experience a kind of despair about being inside this habit, frequently wondering whether there was any point in continuing to talk.

In speaking up for the situation I found myself in, I was also aware of my own personal relief. No analyst should only interpret in order to relieve himself of the psychic pain he may be in, but equally neither should he be ignorant of those interpretations that cure him of the patient's effect. In making my experience available to the patient, I put in the clinical potential space a subjective scrap of material that was created by the patient, and by expressing myself I gave a bit of something of Helen's self back to her.

In the first year of her analysis, Helen was extremely secretive about her relation to her mother, and I did not push her. I sensed that she was protecting both her mother and herself, and on one or two occasions during this first year I told her I felt this to be the case, but I did not urge her to take it up. After some time, when she was clearly ready to do so, she told me how distracted and otherworldly her mother was, and how the mother had only been able to relate to a small portion of her as a child, leaving Helen to live through her childhood in secrecy and in dread of her true self. Her mother's impingement on her true self was her absence from relating, just as, I suppose, I experienced Helen's silences

and absences as impingements in the clinical situation. This was not the case of a daughter hating her mother or of a mother being a hateful person. She was a kindly and loving woman who, nevertheless, absented herself from her children's lives for a number of reasons and left each of her several children severely confused.

CLINICAL EXAMPLES / II

Paul, a man in his late twenties, sought analysis because he insisted that he had never been able to feel close to anyone, and his girlfriend was distraught over his remoteness. True to his self description, he told me about himself and his life in a cold and detached way, although I found it almost a caricature of rationality, that sort of exaggeration of a phenomenon that is almost an invitation for someone to challenge its veracity. I sensed that his remote behaviour in the sessions was not true of him.

Nevertheless, he traversed the analytic terrain taking delight in questioning the intellectual validity of psychoanalysis and scoffing at my interpretations. Often he would tell me that what I had said 'might' be possible, but even if it were true, wasn't it just part of a large sociological phenomenon. He would then lecture me on the nature of the class struggle and the evolution of personal character as a feature of the dialectics of misfortune. It appeared as if his moments of joy in sessions were seized whenever he could reduce one of my interpretations to its latent intellectual assumptions, and he would chortle on about the implicit logics of my analysis: class issues, cultural assumptions, feminist or anti-feminist elements, residual Americanisms, and a multitude of bourgeois interests.

I never felt, however, really insulted or cross with him. Frustrated, yes, and irritated at his investment in some kind of false relating at a manifest level: at his insistence that I see him as a cold and scientific person. In fact, I liked him. I knew, therefore, that my affection for him was a countertransference state that provided some evidence of dissociated loving feelings in him. Indeed, although he did present himself to me in the sessions in the obsessional manner – excreting, as it were, his material to be collected by me into an interpretation, so he could have the pleasure of destroying it – I knew that some of this obsessional behaviour was a tease and that some of his unconscious love was being expressed through homosexual libido.

These obsessional preoccupations and homosexual feelings of his were taken up in the analysis and occupied much of the analytic work during his first year of treatment. Both were, however, compensatory dispositions, alternative ways of gaining satisfaction due to some kind of trauma in his early object world that did not allow for more mature forms of love to evolve.

I knew about his more mature capacity to love from the nature of his transference. Each analyst has an experience of living within the patient's created environment and, although Paul often scoffed at me, tore my interpretations into shreds, and insisted he was a hopeless and monstrous person, he took great care to present me with details of his life. Whenever I had misunderstood something he said, he sensed I had gone astray and very sensitively helped me to restore my understanding. This would take place even when he was ostensibly disgusted by me and dismissive of my interpretations. I 'knew', therefore, through my experience as his object, that in part I was being well looked after, and it was this experience that led me to realize this was an expression of his unconscious love.

There came a point in his analysis when I considered it necessary to use my sense of him as important evidence, and to do so knowing that he would scoff at me and insist that this kind of knowledge has no place in an analysis or in any 'serious' epistemology. Early on, I had told him: 'You want me to see you as monstrous. Well, I don't buy it. You are a bit of a monster, but not nearly as much as you claim.' He would take delight in making light of such a remark, and would often extol the virtues of rational and objective thought, but in such an unbelievable way that on occasion I would say to him, 'yes, of course, you are a robot, I know', challenging his version of himself in a vigorous and humorous way.

Sometimes he would reflect on some event in the world that had caused people great concern, one such moment being an

assassination attempt. 'I can't for the life of me understand why people get so upset about something like this,' he said to me, 'I think I have to ask people about this so I can understand. Why do you think I don't understand?' He said this in a puzzled pseudo-quizzical way, but professionally delivered with the expertise of many years' practice in appearing to have no feelings. When he asked me this 'question', I replied very simply, 'nonsense'. He laughed and asked what I meant by 'nonsense'. I said he knew very well indeed what I meant and that it was, as we were discovering, part of his false self to appear as if he did not have feelings when in fact he did. Invariably in such encounters with him, I would introduce the affective element, as I did when I said 'nonsense'. This brought him out of his false-self coolness into relatedness; he would laugh and clearly be relieved in some part of himself that I saw through his pretences. When he snickered and asked me how I knew he was talking nonsense, I never attempted to explain my statement or engage in a long-winded exchange with him. I decided instead to state that I knew somewhere from my sense of him that he was fooling himself and trying to fool others and that I was content to speak from this area of knowing, even though it was not equivalent with other ways of knowing through the production of 'evidence'.

The trauma in Paul's early object world was soon clear in his analysis. His father had been an exceedingly remote man who had never been part of the family, and it was not difficult to see how Paul's homosexual urges were erotized efforts to find a father (and also to dismiss him). His coldly obsessional false self was his unconscious reconstruction of his father's character. I therefore knew that in standing up for feelings as legitimate factors in human life, I was already in the countertransference a different parent than his father and also a different child than he was, insofar as I was intent upon speaking up for and valuing subjective states as potentially valid. This view of Paul's father and Paul's coldness is only one of several 'correct' reconstructions. It is also true that Paul is so angry with the father that he projects this cold rage 'into' the paternal introject.

There came a point in the analysis, however, when Paul needed in my view a more direct analysis of his unconscious love. I decided that there was a non-traumatic way of speaking to him about my experience as the object of such love. In the course of one session I said to him: 'Well, you will really enjoy scoffing at this; nonetheless, I am aware of your secret capacity to love and look after someone because I am aware of the care with which you help me to understand you in these sessions, and I am aware of your affection for me, all of which I take to be manifestations of those very feelings you insist you do not possess.'

He proceeded to scoff at my remark in a rather half-hearted way, but I could tell from his response that he wanted me to continue and that he was relieved. I said, 'well you crank up the old robot you, but I think you are relieved and pleased that I know what I do about you'.

For some months he would now and then resume for a moment the robot act but I would confront him and analyse how he was dosing me with that cold father he had and how I was in the place that he occupied for so many years. I was sure that he expected me to give in, as had he, and I think that one of the reasons he kept resurrecting his identification with his father was his very real uncertainty about whether I could withstand the situation.

CLINICAL EXAMPLES / III

Joyce is an attractive woman in her middle forties who came to analysis knowing quite a lot about psychoanalytic theory, as she has friends who are psychoanalysts and has also engaged in academic research in which she uses psychoanalytic theory to develop her work. In the first weeks of her analysis I was puzzled by the fact that there was little relation between her narrated version of herself and the person whom I saw and experienced before me. She told me that she was seriously depressed and could not cope with life. She stressed that she lived in a constant confused state, and she claimed that she had no sense of self; indeed, she wondered if she had ever had a legitimate moment in her life.

Of course I have analysed people who do quite rightly make such statements, but they tend to demonstrate this fact through their behaviour in sessions. Joyce was fairly radiant. She was

animated and reflective. She seemed in touch with her affects and did not experience undue anxiety in the sessions, nor did what she described as a depression seem to be depression as such; I sensed that it was more like an enveloped sadness that she had carted around with her through her life. When she talked about living in chaos, not having a sense of self, and wondering where her true self was, I was a bit suspicious. More than once I have been sought out by patients who want what they think of as a Winnicottian analysis, and such people often come with a lament collated from his theory of the true and the false self.

Joyce presented herself in the sessions as a chronicle of confusion, despair and emptiness, and during the first weeks of her analysis I listened and said little except for the occasional clarification. I was, however, immediately presented with a dilemma, since I thought that to continue to analyse her material without conveying my sense that it was strangely untrue would be to sustain a false analysis. I therefore told her that I was puzzling over something and that, bearing in mind that I was making my sense of something available only to further understanding of her and that I might well be wrong, I felt that she just did not strike me as the wrecked person that she claimed to be. She met this comment with rather intense intellectual aggression and insisted that she was every bit as useless and inept as she claimed, so my comment became a part of the seemingly irrational affective element of the session and subsequent sessions: where did it come from, and what did this comment mean?

Meanwhile my sense of her did not change. It was not only that Joyce reported professional accomplishments which in themselves refuted her notion of incompetence, but her liveliness in the session was transference evidence, from my point of view, of the presence of true self activity. When she talked about other people in her life or certain situations, she did so with humour and mental acuity and I found that I enjoyed her. Whenever she would turn her narratives to herself as an object, however, she would lower her voice and lambast herself by listing her latest failures. All of this was in the context of her wretched climate of living with no sense of self.

For reasons of space, I shall not list all of the psychodynamic considerations and possible transference explanations I thought about during these early months of her analysis. I did know from her that her early relation to her father had been very good and that he had fairly worshipped her, but that when she was about six years old he withdrew because of ill health. She receded into herself, although she devoted quite a lot of time providing her father with psychological support. It became clear that when she had lost him, she also lost his relation (and her own) to herself as an ideal object. I interpreted this and analysed her presentation to me of the so-called depressed self and absence of self as forms of contempt: if she could not be that princess she once knew herself to be, then she would accept nothing as valuable. Indeed, to trash all of her objects – her work, her friendships and her own self – expressed an unconscious demand that she knew she deserved better. In many ways she confirmed this interpretation although she did not like it, but its effectiveness was often due to my consistent refusal to believe her assertions that she really was a wreck.

Of course I do not make light of her difficulties. Her unconscious grandiosity, itself the memory of a relation with her early father, is expressed by her destruction of those things that are valuable in her life, and this creates a depressed atmosphere which re-creates the other relation to her father, as she nurses those objects in her life (including herself) that she has devalued. Indeed, by presenting me with a 'schizoid' patient or one suffering from a 'basic fault' (she knew Balint's work) she was giving me a gift, as I was meant to have my narcissism enhanced by resurrecting this wreck of a person into the possession of self and the actualization of true self states. I was meant to be a miracle maker, and her transference was unconsciously designed to nurse me into meaningfulness, in effect, to restore the father and herself to a previous golden era.

As time went on, however, I was faced with a more difficult problem than the initial puzzles. She accepted and worked with the interpretations about her unconscious grandiosity and

understood how this was a kind of memory. She lived through a recognition that what she termed depression was a mixture of phenomena: the destruction of her objects, an inverted expression of her anger and the location of true sadness over the loss of her father. Increasingly, however, I felt that she was living at some very considerable remove from people, including myself in the transference. This 'fact' of her character was by no means obvious. Indeed, she appeared to be quite the reverse, and the matter was further complicated by the reality of her genuine health and ego capacity. But I continued to feel uneasy about the analysis. She was absenting herself in a most subtle manner, and I could not find evidence for this in her presented material.

Fortunately she missed several sessions in one month and came late for a few others. This acting out became a turning point in her treatment, as it enabled me to reach areas of her that had previously been unknowable. When she arrived late for one session, she apologized and told me that she had been late for everyone that day, and, unfortunately, for me as well. I asked, 'you mean we are all the same?'. This comment was mildly irritating to her, as she felt I was placing undue emphasis on her passing remark. I challenged her in this manner because I was determined to reach through her health, ego capacities and object relatedness (which I had originally 'fought' to validate in the analysis) in order to find out where she was and why she was internally removed.

In the course of the session, I decided that I would have to use something of my own experience of her in order to place what I considered essential material into some space where both of us could work on it. I said: 'You know, I want to put forth for mutual analysis a feeling I have, because I think it is essential to do so in order to find you. I have this sense that you are only partly here in this analysis and that you have resigned yourself to a failed therapy, even though it will have appeared on the surface to have been meaningful.' At this point she launched into vehement protest. 'Look,' she said, 'I make everyone feel this way. There is no reason why you should take it that way, that is personally.' I answered: 'Perhaps what I have said has made you feel guilty which was not my intention, and now you are working to relieve me of what you regard as my distress, but in fact I feel that in putting it to you as I have done I am at least getting to grips with something that ails you.' She said, 'well I am like that with everyone', and stressed this several times. I went on: 'Oddly enough, when you say that, I am aware of realizing where my feeling comes from; as long as all of your experiences are democratic ones, no one person would appear to have any individual significance.'

I was encouraged in making this later interpretation by her vehement protest to my first intervention. The protest was more an animated and provocative plea for me to take the issue up and follow it through; it was not that sort of irateness that constituted true despair over a misunderstanding on my part. Indeed, we were very much in the midst of a struggle, and the reader may not be so terribly surprised to discover that she was concealing a loving transference neurosis. In the months to come, she managed to fall in love and to speak from the painful position of such need and internally private intimacy. In the many months it took to work through the infantile components of this transference neurosis, she repeated on several occasions that she had never originally believed that analysis could really help her but that my refusal to accept her original accounts of herself as a desperately ill person had given her hope that perhaps she might be found after all. She regarded the firm yet non-traumatic way I asserted my sense of conviction about her as the most important factor in her eventually entrusting me with her love and with those loving memories of her father.

CLINICAL EXAMPLES / IV

It is utterly impossible to describe the course of George's analysis in the space I have allocated here, and I shall only say that he is an Irish manic depressive psychotic, who has had several hospitalizations for his illness, and who can be both terrified and terrifying at the same time. In his middle twenties, more than six feet four inches, he is something of a frightening character when he becomes enraged in the consulting room, particularly as he

dresses entirely in black. Over the years, however, I have managed to find a way to live inside the environment he creates, and I have done so by analysing him even when he threatened to murder me if I didn't shut up. As time went on, what had been violence in him transmuted into a more libidinally aggressive situation, as I would stand up for myself when he told me he would kill me. On one such occasion, when he instructed me to shut up or he would have to shut me up, I said, 'look George, killing me would be redundant, as you spend most of these sessions insisting to yourself that I am not really here anyway'. I delivered such comments with vigour and firmness but not hostility, and over time he gradually began to need this kind of response from me in order to engage me aggressively, a process that continued for years and that mitigated his violent thoughts and his terror of actually encountering someone.

The issue I shall take up here, however, arose after some three years of analysis. Of course I had had many occasions to analyse his grandiosity, his omnipotence and his utilization of saint-like innocence (denial), and to his credit he was able to survive analysis and make increasing use of it. There was one characteristic of his transference, however, which did not budge, even though I had brought it to his attention one way or another in every session. This was his tendency to tell me something about himself (let's say some observation of an action on the previous day) and the moment I took it up with him, perhaps to interpret it, perhaps simply to clarify it, he would always change his original version. The degree of change varied. Sometimes he would simply correct my syntax as I might have put it just a bit differently than he did. Other times he might edit out adjectives and take out the essential element of his remarks. On more unfortunate days (for me) he would deny having said anything at all. My interpretations of this also varied according to his ability to use understanding on any one occasion, but I stressed his anxiety, his need to control the situation and his despair that I did not live inside him, so that having to tell me something about himself was very distressing, for it implied my separateness. I won't comment further on the differing interpretations, only that after some three years

of analysis he continued to do the same thing. Then one week he was a shade different. On the Monday he was able to bear my analysing something without changing the details, and I noticed that the material he reported was more specific and less of the abstract kind of lecture on himself he was prone to furnish as a way of preserving his secrecy. On Tuesday I discovered that he remembered what I had said on the Monday and indeed seemed to be making some analytical use of it, so I found myself shifting a bit inside, as I knew that I was feeling that just possibly he was changing. On Wednesday he completely re-edited Monday's material, wiped out our Tuesday session and eradicated the sense I had had that we were possibly beginning to work together. I recall that for some fifteen minutes into the session I was saying to myself: 'Oh what's the use? The son of a bitch is hopeless. You can't do a thing. Just let him rattle on for the whole goddamn session and don't bother to find a way through to him.' My response shocked and bothered me, for, although I had often felt futile and very angry with him, I had never reached this point. In my countertransference I was clearly feeling some rather dreadful loss.

I decided against proceeding along my ordinary analytic line of interpreting and communicating what he was doing and why I thought he was doing it. In my view this would have amounted to a kind of collateral dissociation through analysis, with me simply providing a process description of what he was doing, amounting to a kind of musical score. Instead I knew that I must get through to him and that I had to find some way to reach him, as otherwise, despite his being an analytically interesting person, I thought he would be one of those unfortunate sort of people who spend a lifetime in analysis but are no different for it.

I therefore opted to try to describe the position I found myself in, and I am quite sure that the very way in which I began to speak somehow drew his attention far more acutely than any of my previous interpretations, since I was clearly struggling to break through to something in myself as well. I said, 'George. Stop talking for a minute. I want to say something to you. I am aware of feeling utterly hopeless, and I have been wondering if it is at all

possible to get through to you.' He went very still on the couch. 'Let me tell you of my experience and, if you can bear it, I think that it might possibly help us to understand this situation a bit better.' As much as what I had said up to this point was effective, I think it was my tone of voice, which I find impossible to describe in retrospect, that reached him, and he seemed to relax. 'My experience is that just when I think I have understood you and when we have established a mutual recognition of something about you, you disappear.' He heaved a great sigh of relief on the couch and said 'yes' so very quietly that I didn't realize he had said anything at that moment until after the session was over. I waited a moment, trying to collect my thoughts together and aiming to put them in a manner which he could use, and then I said: 'You tell me something about yourself, I am just in the process of digesting it and storing it for further understanding of you, and then along you come – wham! – and tell me what I have digested and stored inside me did not come from you at all. The problem I find is how to live with this despair occasioned by your disappearances.' There was a pause of a few minutes, and George seemed very deeply relaxed. I felt an enormous relief in myself, as if at long last I had been able to speak the truth, to stand up against something, and yet at the same time I felt that I had also stood up for George as well.

By way of parenthesis, I should say that by this point in the analysis I of course knew a great deal about his early childhood. As an infant he had been separated from his mother on several occasions and she left him in the care of a series of people – not nannies – while she went off to work. She had to leave him not because she hated him, but because she was depressed and could find narcissistic replenishment only in her work as a volunteer. George had never established a relation to his father, who was kindly but remote and who disliked the role of father. George was sent to boarding school in Europe and that was, in effect, the last the family had to do with him.

After several minutes' pause in the session reported above, I decided that such a direct use of my countertransference had to be used analytically, so I told him that I thought that my own

experience was like that of an infant in relation to a mother; suffering this disappearance was, in my view, exactly the position that he must have been in during the first years of his life. Now you see mother and begin to internalize her, and now you don't see her, but a new mother cropping up each time. I said that the analyst was to some extent dependent on the patient, and in this sense, his position could at times be like that of an infant dependent on the analysand for 'feeding' or 'playing', and that my sense of hopelessness and futility must reflect his own infant self confronted by someone who would, it seems, have nothing to do with him.

I was quite aware that the analytical comment was somewhat intellectualized and that it was explanatory, but I was quite content that it should be so, as the patient had just received a direct countertransference comment from me. I thought he needed some kind of frame into which he could place countertransference interpretation.

It became clear from the follow-up sessions that George had always known about the position in which I was meant to live a life with him. My previous analysis of his anxiety and his defences against anxiety, although correct, had never reached the core of the issue, and later he told me that he despaired that I would ever speak up for myself. When I did, this did not burden him with a sense of guilt. Quite the opposite, since the fact that I had not personally resisted his created environment had left him feeling doomed and monstrous.

CLINICAL EXAMPLES / V

Jane is the sort of patient that clinicians often term a 'malignant hysteric'. Over the years this East-European woman in her late forties had managed to perfect a technique of exploiting all of her nascent affects into strategic devices to coerce others into some form of submission. If, for example, her boyfriend had been unkind to her and she had felt quite legitimately hurt, she would sense that such a position put her at an advantage with him. She would then hyperbolize her pain into pseudo-dementia compelling the boyfriend into a depersonalized sol-

icitousness. If she felt guilty in a session about something that she had done to someone, and if I clarified with her her sense of guilt, she would raise her voice and berate herself with incredible emotional violence, knowing that she now had a true affect around which to cohere a moment's personality.

I have written about some features of my countertransference with Jane (see above, chapter 11), particularly my awareness that early on in her therapy I tended just to look at her rather than listen to her. She sits across from me in psychotherapy, and I noticed that it was her gestural and visual presence that I was drawn towards, a phenomenon enhanced by the fact that she is strikingly beautiful. In considering this countertransference phenomenon, I gradually realized that, as is true with many hysterics, she did not believe that the other would internalize her (that is, think about and consider her), so she needed to affect the other in different ways. As time went on, however, I was also aware that my pleasure in the sight of her was a defence against her emotional life which I found quite paralysing. Indeed, such was the intensity of her representation of mad scenes in the consulting room that I became remote and tried to steer clear of the intensity of her transference. I became aware, that is, of the numbing of my self states while I was in her presence, a phenomenon common in clinicians who work with very hysterical patients. With the contemporary hysteric it is not her body and self that is innervated but the analyst who is innervated in his countertransference.

Often her actions in any one session were so unpredictable, her moods so varying, that I never had a sense of where she was. Once she leapt out of her chair and flung herself towards my window while at the same time turning herself around to face me, shrieking out: 'What is that nice little yellow flower out there in the patio. It is so dear and sweet. And it's so nice that you take care of flowers like that. Life is wonderful, don't you think? The birds, the flowers, the trees.' At these moments she was the personification of an unbelievably scatty woman, and when she suddenly screamed something out, she would frequently get people in the surrounding area to be concerned about what was happening.

Such was her expertise at distressing people that I gather that her previous therapist was greatly relieved when Jane left the analysis, and the highly skilled and experienced psychiatrist who provides me with medical cover telephoned me immediately after seeing her, informing me she was not at all sure that she could provide psychiatric cover since she found her extremely upsetting.

For quite some time I was interpretively firm. I would concentrate on how she felt she could only communicate with someone if she could coerce him. Whenever she was attempting this with me (which was almost constantly), I would calmly inform her of what I thought she was doing. Although this did settle her a little, and eventually became the bread and butter of our work, I was nonetheless aware that personally I found her traumatizing and that I had withdrawn from my more ordinary analytical self, hiding somewhat behind a classical stance. I would often privately regret having her as a patient and would think of a way to get rid of her: maybe she would move away or become disillusioned with me and want to go to someone else; or, if I was lucky, she would have a real breakdown, and the hospital would take her off my hands. I thought I would have to tell her that unfortunately I was unable to continue with her, that private practice has its limits, and so forth. I knew, however, that these feelings were the emergence of her primary objects. Clearly I was beginning to become the outline of the mother who was rid of her when she was a small child, and my fortitude in sticking my ground, interpreting the transference, and placing her idiom in a genetic reconstruction began to have some effect, and – to my disappointment, I can now confess – she felt I was helping her.

Then one session she came and plunked herself in the chair, a kind of silly grin playing on her face. When she leaned forward to look directly at me in what was meant to be a searching inquiry, she said: 'Uh, Mr Bollas, uh, Mr Bollas, it sounds so funny to say that [she laughs], don't you think it would be nice if you could just be a teeny bit warmer [A gushing effusive laugh

follows this]. I mean, I wonder if you could just be a teeny bit warmer. Not much warmer. Just an insie bit. It's just that you are so cold.' It is impossible, I fear, to convey just how maddening this woman could be, as the unreality of her self presentations almost defies communication. When she first embarked on her scripted, searching comments, I thought, 'oh my god, here we go again'. I felt quite differently, however, when she said that she thought I was cold because, although her delivery of this feeling was hysterically conveyed, the essence of the message was correct. I knew that I had withdrawn from her and that I was always on the alert for her next use of herself as a kind of afflicting event.

I decided that this would be an appropriate moment to make my experience of her available for the analysis. I said: 'I am very glad that you have said this because, in a way, I think you are absolutely correct. I have become somewhat cold as you put it, and I am aware of being distanced in these sessions, something that I think you are well aware of. But let's wonder, shall we, about how this happened. You see, it's my view that if you could convince yourself to stop being so goddamned traumatic, then I could be quite a bit more at ease with you, and we could actually get down to the task of understanding you.' To my surprise and relief, she said 'uh-huh' and seemed to mean it. I felt she had come into a different region of herself through the interpretation, an area of the self that I had not seen up till then. I lost heart for a moment when she created a look of studious innocence and said, 'I traumatize people? I upset them? Hmm. Could you just tell me something about that, about how I do it?' I replied: 'What, and make it look as if I am the only one in this room who knows about this? I believe you know very well indeed what I am talking about. In fact I think you brought up my distance from you because you know this element in your life needs recognition and resolution.' She said in a mature voice, which up till then I had simply not heard: 'Yes [pause] I do know. I know all about it. No one has ever lasted me. I drive everyone away from me.' This statement was true. Friends, such as they were, had deserted her. Employers would only last a few weeks. Colleagues asked to be placed elsewhere. Flatmates threw her out. And she protected herself against the immediate loss of family members by only occasionally visiting them, in that way preserving them against her destructiveness.

My direct use of my countertransference, in which I told her how it felt to be one of the objects in her environment, proved to be the turning point in her psychotherapy and allowed me to analyse her false self. I was able to identify her unbelievable self, which was often announced by saccharine confessions. This false self was even more maddening when she delivered rehearsed replays of insight derived from the sessions: 'Oh, I just know that this is what you were saying to me last time, isn't it? Here is me, just little ole me, doing this kind of thing again, huh? Isn't that it, huh?' Wincing may not be a finer articulation of countertransference feelings but I found it effective, as it gave her notice of an interpretation, such as 'you haven't thrown enough sugar on your remarks'. Crass as it may sound, I made comments like these with a sense of relief; they enabled me to feel warmly towards her. She felt met by such comments and would say in a remarkably different and authentic voice, 'uh-huh, you mean the same old stuff', to which I would nod affirmatively.

I have no doubt, both from my own clinical experience and from the accounts of other analysts, that it is quite possible to conduct a more classical analysis with neurotics and some characterologically disturbed patients and to feel that one is real and that the analysis is real. Yet there are certain patients with whom one cannot do classical work and at the same time feel real; indeed, it becomes necessary first to restore one's sense of personal reality in work with such patients before a more classical analysis can be initiated. The occasional direct use of one's countertransference as the object of the patient may be what is needed to initiate analysis proper. Although it could never become a substitute for contemporary 'classical' analysis, it is my view that without such interventions, a patient may be analysed but never reached and, inevitably, never helped by the analytical process.

THE SHADOW OF THE OBJECT

Patients convey their internal world through the establishment of an environment within the clinical situation, and they necessarily manipulate the analyst through object usage into assuming different functions and roles. Very often the location of freely associated ideas – of those thoughts that spontaneously register the content of psychic life – is in the psychoanalyst. This is so because the patient cannot express his conflict in words, so the full articulation of pre-verbal transference evolves in the analyst's countertransference. The transference-countertransference interaction, then, is an expression of the unthought known. The patient knows the object-setting through which he developed, and it is a part of him, but it has yet to be thought. The psychoanalytic understanding of the transference-countertransference discourse is a way of thinking the unthought known.

I believe that it can be valuable for the clinician to report selected subjective states to his patient for mutual observation and analysis. By disclosing some of his subjective states of mind, the analyst makes available to the patient certain freely associated states within himself, feelings or positions that he knows to be sponsored by some part of the patient. Even though the clinician may not know what the ultimate conscious meaning will be of a subjective state of mind, or of a position he will find himself in within the countertransference, he can put it to a patient so long as it is clear to the analysand that such disclosures are in the nature of reports from within the analyst in the overall interest of the psychoanalysis.

I do not think that most interpretations should be either statements of feelings or senses within the analyst or direct disclosures of the positions in which the analyst finds himself. Such is the near-phobic dread of this area of technique within psychoanalysis that I shall state that the analyst must use such interventions sparingly, and only to facilitate the analytic process. Furthermore, it is essential that the clinician analyse those responses in the analysand which are unconscious reactions to or unconscious comments on the phenomenon of the analyst using his subjective state or reporting his direct countertransference

experience. For example, the clinician may say, 'I think you believe I have said this because I am fed up with you, and your response is a kind of apology.' Or, 'I think you are worried and believe something has gone wrong with me. You have decided that now I am the patient and you have a distressed analyst on your hands, such is the worry occasioned by my putting forth a feeling for consideration.' Alternatively: 'You seem amused, and I wonder if it isn't because you are thinking something like "Ah. He's done it! He has broken the rules and I have found him out!" thus giving you a curious feeling of triumph.' Or: 'I think you are finding it very difficult to consider what I have said, as you are, for the moment, excited by the way I have said what I did.' In other words, each analyst must be thoroughly tuned in to the patient's unconscious response to his intervention, as Langs (1979) and Casement (1985) have stressed in their writings. So long as this unconscious reaction or comment is fully analysed, the analyst can proceed to elaborate the aim of this disclosed subjective state, should that be necessary.

I have stressed that I do not believe the clinician should make a direct use of his countertransference without establishing over time meaningful precedents for the occasional examination of the analyst's subjective states, a fairly unremarkable phenomenon in that I am referring only to those kinds of intervention when the analyst says 'I feel', or 'I have an idea', or 'I sense that'. Such interventions, however, are countertransference-inspired and indicate some aspect of the analyst's trust in his subjective states of mind. Furthermore, by virtue of his own self relating in the presence of the patient, the analyst can verbalize subjective states and contemplate them openly, or he can correct himself in the presence of the analysand, thus demonstrating his own comfort with the subjective element by using the analytical method to understand some of his own states of mind.

The analyst's disclosure of a selective subjective state of mind is not equivalent to the expression of affect (for example, 'you make me angry') or the revelation of an unanalysed feeling or phantasy. When I disclose a subjective state to a patient, I do so with more concentration than when I make a clarification or

present an interpretation. More mental work goes into the evolution of the statement 'I feel' or 'I sense' than I bring to interpretation proper, precisely because disclosures of subjective states process much that is still the unthought known, and one's intelligence here is an invaluable asset in articulating the unthought known. If one is thinking very carefully, then in the moment of saying to a patient 'I sense', the analyst conveys that such phrasing is both a thoughtful moment and an occasion for the unthought to be given its space for articulation, such as with immediate and often inspired associations of the analysand. Ironically, even though I say 'I sense' or 'I feel', the articulation in such a moment reflects thoughtfulness rather than affectivity or mystifying intuitiveness. The analysand understands that the psychoanalyst's relation to the unthought known is thoughtful, even though the core of significance has yet to be discovered. This relation of thought to the unthought is a useful one in our clinical work. It allows me to tell a patient that I am not convinced by his explanations of his state of mind, even if I don't yet know what it is that we have yet to understand.

I am aware that some clinicians who value countertransference believe that the analyst should only make private use of this information and then make transference interpretations. This is often accomplished by saying, 'I think you are telling me something by showing me how it feels', an intervention which may in some ways be correct, but which sidesteps the truth a bit. To be sure, analysts do learn from their countertransference experience, and it is often true that up to a point patients do have a sense that they are communicating with the analyst by forcing him into a certain position within a session. The patient and analyst may not know for a long time what the meaning is of a cumulative establishment of the transference, but by making certain subjective states known to the analysand, the analyst enables the transference-countertransference discourse to be analysed as it develops.

If I had said to Helen, for example, 'I think through your self interruptions you intend me to have some knowledge of what it means or feels like to be lost', I believe this would not have been entirely true, since the reliving of one's history – full of communicative potential as it is – does not mean that the sole unconscious aim of such a reliving is to inform the other about oneself. I do not pretend that the originating subjectivity behind the need to make the patient's transference known springs from the analysand when, in fact, I know the genesis of such interpreting comes from myself. Many patients would be quite content to remain unconscious of their transference usage of the analyst. Admittedly, I did say to Helen that I thought she was creating absence and I suggested that she aimed for me to know this, but my intention is to provide a potential space in which the analysand can give consideration to the unconscious motives that organize her character. In my view, an interpretation of projective identification would have been false. My interpretation was only meaningful to her because the transference interpretation followed my countertransference disclosure.

If I had merely interpreted to Paul that he intended to inform me, through his transference idiom, what it is like to be cold-shouldered by his father, I think that the ironic effect of such an interpretation would have been the unfortunate maintenance of an aseptic world, since my interpretations would only have sounded like odd echoes of his remote father. Paul needed me to use my own rapport with my subjective feelings in order to stand up for his potential self. In speaking up for what I felt or sensed, I was, of course, representing in the analysis a split-off position of the analysand, but in my view, the only way I could authentically reach this person was to speak for that which he had disowned.

When an analysand uses language on the cheap, it is not only the case that the patient may be discharging himself of pain or excitation, but also that the analyst's words are not valued as symbolic representations of meaning. In the more classical situation the analyst used that silence which is the hallmark of most analyses as a background from which speech expressed meaning, and patient and analyst listened to the free associations. Susan Sontag brilliantly states the uses of silence:

> Still another use for silence: furnishing or aiding speech to attain its maximum integrity or seriousness. Everyone has

experienced how, when punctuated by long silences, words weigh more; they become almost palpable. Or how, when one talks less one begins feeling more fully one's physical presence in a given space. Silence undermines 'bad speech', by which I mean dissociated speech – speech dissociated from the body (and therefore from feeling), speech not organically informed by the sensuous presence and concrete particularity of the speaker and by the individual occasion for using language. Unmoored from the body, speech deteriorates. It becomes false, inane, ignoble, weightless. Silence can inhibit or counteract this tendency, providing a kind of ballast, monitoring and even correcting language when it becomes inauthentic. (1966, p. 20)

However, silence in an analysis does not initially function in this manner with the less neurotic and the more severely disturbed character disorder. Words weigh for nothing. Some patients may, alternatively, not speak at all, except for lifeless mumblings, since they exist in a kind of listless inertness. The analytical task is difficult and challenging with such patients, as the analyst must find some way to give weight to language, to give it body. By using language to speak selected subjective states, and by struggling on occasion to find the right words to express my states of mind, I am trying to give to language its meaningful representational potential. What I am concerned with is close to Masud Khan's concept of interpretation following the 'vectors of being and experiencing' (1974). It is related to Bion's idea of the evolution from beta to alpha functioning and thinking (1977). It is also relevant to Langs' typology of transference communications (1979).

The clinician, that is to say, must function openly as a transformational object. He must indicate that he perceives something, even if the perception is only of an as-yet-inarticulate movement of a potential significance, registered through a feeling state or a sense in one's being. He must trust such a perceptual registration as a potential source of knowledge, and he must transform the inarticulate sense or feeling into some form of verbal representation that can be put to the analysand for mutual consideration. This inarticulate element is the unthought known; the patient knows something, but has as yet been unable to think it. The analyst here performs much the same function that the mother did with her infant who could not speak but whose moods, gestures and needs were utterances of some kind that needed maternal perception (often achieved through a kind of instinctual knowing), reception (a willingness to live with the infant utterance), transformation into some form of representation, and possibly some resolution (the ending of distress).

I think it is necessary for the analyst to use himself more directly as an area of shared knowing through his experiencing, if he is to reach many of his patients. From his own experiencing, the analyst may not only establish the value of feeling states and subjective states, but he may also find a way to use this form of countertransference experiencing for eventual knowing. In this way the unthought known, which can only be thought via the subject's use of the object in the transference and countertransference, is given its place in the fields of analysis. The psychoanalyst's establishment of an intelligent subjectivity, in which he works to put his self states into language, constitutes an important part of the work (of thought) of analysis. If he cannot find a way to do this, it is my view that he may well preserve in the patient a quiet belief that psychoanalysis turns away from very significant areas of being, knowing and truth.