

Analyising the Matrix of Transference

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The analyst must have a theoretical framework with which to conceptualize not only the nature of the relationships between transference figures occupying the analytic stage, but also the matrix (or background experiential state) within which the transference-countertransference is being generated.

Over the past forty years there has been an expanding appreciation of the importance of the analytic context, not simply as a framework for the containment of the analytic process, but as a pivotal dimension of the transference-countertransference. Melanie Klein (1952a), for example, stressed that one must 'think in terms of total situations transferred from the past to the present as well as emotional defences and object relations' (p. 55). Betty Joseph has elaborated on this idea: 'By definition transference must include everything that the patient brings into the relationship. What he brings in can best be gauged by our focusing our attention on what is going on within the relationship, how he is using the analyst, alongside and beyond what he is saying' (1985, p.447).

Winnicott's (1949), (1958), (1963) conception of the 'environment-mother' has greatly enhanced the analytic conception of 'the matrix of transference' (1958, p.33). The infant not only has a relationship with the mother as object, but also from the beginning has a relationship with the mother as environment. Consequently, transference is not simply a transferring of one's experience of one's internal objects on to external objects; it is as importantly a transferring of one's experience of the internal environment within which one lives on to the analytic situation. (Among those who have contributed to the development of the concept of transference to the mother-as-environment are Balint [1968], Bion [1962], Bollas [1987], Boyer [1983], R. Gaddini [1987], Giovacchini [1979], Green [1975], Grotstein [1981], Langs [1978], Loewald [1960], McDougall [1974], Modell [1976], Pontalis [1972], Reider [1953], Searles [1960], Viderman [1974], and Volkan [1976].)

In the present paper, I shall discuss an aspect of the analytic context that is related to, but distinct from, those elements addressed by Klein, Winnicott and those who have extended and elaborated on their work. I shall take as my focus an exploration of the way in which experience in general, and transference-countertransference experience in particular, is the outcome of the interplay of three modes of creating psychological meaning: the autistic-contiguous, the paranoid-schizoid and the depressive. The dynamic interplay of these modes of generating experience determines the nature of the background state of being (or psychological matrix) within which one is living and constructing personal meanings at any given moment. As a result, an understanding of these modes of generating experience and the experiential states associated with them is essential to an understanding and interpretation of the transference-countertransference.

I shall begin by briefly summarizing my own understanding of the three fundamental background states of being constituting the context of all human experience including the transference-countertransference. I shall then present several fragments of analytic work which illustrate some of the ways in which psychoanalytic technique is shaped by the analyst's understanding of the predominant (but ever-shifting) mode or modes of experience forming the context of the transference-countertransference.
DIMENSIONS OF EXPERIENCE

All human experience, including transference-countertransference experience, can be thought of as the outcome of the dialectical interplay of three modes of creating and organizing psychological meaning. Each of these modes is associated with one of three fundamental psychological organizations—the depressive position, the paranoid-schizoid position, and the autistic-contiguous position.1 (The depressive and the paranoid-schizoid positions are concepts introduced by Melanie Klein [1935], [1946], [1952b], [1957], [1958] while the autistic-contiguous position is a conception that I have introduced in previous communications [Ogden, 1988], [1989a], [1989b] as an elaboration and extension of the work of Bick [1968], [1986], Meltzer [1975, 1986]; [Meltzer et al., 1975] and Tustin [1972, 1980, 1981, 1984, 1986]). None of the three modes exists in isolation from the others; each creates, preserves, and negates the others dialectically. Each mode generates an experiential state characterized by its own distinctive form of anxiety, types of defence, degree of subjectivity, form of object relatedness, type of internalization process and so on.

The autistic-contiguous position is associated with the most primitive mode of attributing meaning to experience. It is a psychological organization in which the experience of self is based upon the ordering of sensory experience, particularly sensation at the skin surface (cf. Bick 1968), (1986). In an autistic-contiguous mode, the predominant anxiety is that of the collapse of the sense of sensory-boundedness upon which the rudiments of the experience of a cohesive self are based. This loss of boundedness is experienced as the terror of falling or leaking into endless, shapeless space (Rosenfeld, 1984). The individual often attempts to defend himself against this type of anxiety by means of ‘second skin formation’ (Bick, 1968), (1986). Examples of defensive efforts of this sort include tenacious eye contact, continuous and unrelenting talk, compulsive wrapping of oneself in many layers of clothing, etc.

The experience of objects in an autistic-contiguous realm is primarily in the form of 'relationships' to autistic shapes (Tustin, 1984) and autistic objects (Tustin, 1980). These autistic phenomena are quite different from the shapes and objects that we ordinarily think of as constituting the object world. An autistic shape is a 'felt-shape' (Tustin, 1984) consisting of the idiosyncratic sensory impressions that an object makes as it touches the surface of our skin. For example, a rubber ball is not the round object we perceive in a visual and tactile way; rather, it is the feeling of an area (the beginnings of a place) of firm softness that is created as the object is held against the skin. Autistic shapes are predominantly experiences of soft objects (devoid of any sense of 'thingness') and bodily substances (for example, saliva, faeces, and urine). Such primitive 'object-related' experiences (experiences of contiguity of surfaces) are soothing and calming in nature.

In contrast, 'relationships' to autistic objects are experiences of hardness and edgedness that create the sensory experience of a protective crust or armour. For example, the experience of an autistic object may be created by pressing a hard, metallic object such as a key into the palm of one's hand. One does not feel the pain of a key digging into one's skin; rather, one feels the safety of having (being) a shell.

In the autistic-contiguous position, psychological change is mediated in large part by the process of imitation (as opposed to incorporation, introjection and identification which all require a more fully developed sense of an inner space into which qualities of the other can, in phantasy, be taken [cf. E. Gaddini, 1969]). In imitation, the qualities of the external object are felt to alter one's surface thus allowing
one to be 'shaped by' or 'to carry' attributes of the object.

The paranoid-schizoid position (Klein, 1946), (1952b), (1957), (1958); (see also Ogden, 1979), (1982), (1986) generates a more mature, differentiated state of being than that associated with the autistic-contiguous position. The paranoid-schizoid dimension of experience is characterized by

1 It is beyond the scope of the present paper to offer more than a schematic overview of the major psychological organizations and the dialectical interplay between them. For a more detailed discussion of these topics see Ogden, 1985, 1986, 1988, 1989a, and 1989b.

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a form of subjectivity in which the self is experienced predominantly as 'the self as object'. In this experiential state there is very little sense of oneself as the author of one's thoughts and feelings. Instead, thoughts and feelings are experienced as forces and physical objects that occupy and bombard oneself. While the autistic-contiguous position can be thought of as presymbolic, the paranoid-schizoid position is characterized by a form of symbolization (termed symbolic equation[Segal, 1957]) in which there is little capacity to differentiate between symbol and symbolized. In other words, there is almost no interpreting 'I' interposed between oneself and one's lived experience. As a result there is an intense sense of immediacy to one's experience. In the absence of a sense that experience can be thought about, psychological defence tends to be enactive and evacuative in nature. One attempts to separate the endangering and endangered aspects of self and object (splitting) and to make use of others to experience that which one finds too dangerous to experience for oneself (projective identification).

In a paranoid-schizoid mode, the individual has achieved only a rudimentary sense of himself as an interpreting subject and, therefore, the other is similarly experienced as an object as opposed to a subject. Consequently, there is little capacity for concern for the other: one can value objects, but one cannot have concern for even one's most valued possessions. In the absence of the capacity for concern, guilt remains outside of the emotional vocabulary of this experiential state. Lost objects are not mourned for, they are (in phantasy) magically repaired or re-created.

This is a relatively ahistorical experiential state since the use of splitting renders one's experience of oneself (in relation to one's objects) discontinuous. A beloved object who is suddenly absent is not experienced as a frighteningly unpredictable good object, but as a bad object. In this way, one's loving self and objects are kept safely disconnected from one's hated and hating self and objects. The result is a continual rewriting of history and a rapidly shifting sense of self and object. With each new affective experience of the object, one 'unmasks' the other and discovers the 'truth' about who the object is and always has been. Anxiety in this realm of experience takes the form of the fear of impending annihilation and fragmentation resulting from the destruction of loving aspects of self and object by hated and hating aspects of self and object.

The depressive position(Klein, 1935), (1958); (see also Ogden, 1986) is the most mature, symbolically-mediated psychological organization. In a depressive mode, there is a much more fully developed sense of an interpreting self standing between oneself and one's lived experience. In this experiential state, one's thoughts, feelings and perceptions do not simply happen like 'a clap of thunder or a hit' (Winnicott, 1960, p. 141); one's thoughts and feelings are experienced as one's own psychic creations that can be thought about and lived with and need not be immediately discharged in action or evacuated in omnipotent phantasy.

As the individual is increasingly able to experience himself as a subject, he also begins to recognize (by means of projection and identification) that his objects are also subjects who have an inner world of thoughts, feelings and perceptions similar to one's own. As a result of one's growing awareness of the
subjectivity of the other, it becomes possible to experience concern for the other; one knows that the other feels pain that is as real as one's own and that that pain cannot be magically undone or repaired. With the development of the capacity for concern comes the capacity for guilt, remorse, and the wish to make non-magical reparation for the actual and phantasized harm that one has done.

As reliance on omnipotent defences is relinquished in the depressive position, historicity is created. As has been discussed, in a paranoidschizoid mode, history is continually being defensively re-written. In the depressive position, for better or for worse, one is stuck in the present. Past experiences can be remembered and at times re-interpreted, but the past remains immutable. There is sadness, for example, in the knowledge that one's childhood will never be as one wishes it had been, but one's rootedness in time lends stability to one's sense of self.

In summary, the three positions that have been discussed represent dimensions of all human experience. No single realm of experience is ever encountered in pure form any more than one ever encounters consciousness disconnected from unconsciousness. Each dimension of experience is created and negated by the others. The autistic-contiguous mode provides much of the 'sensory floor' (Grotstein, 1987) of experience; the paranoid-schizoid mode generates a good deal of the immediacy and vitality of concretely symbolized experience; the depressive mode allows for the creation of an historical, interpreting self. The three positions are related to one another both diachronically and synchronically. That is, there is a chronological, sequential relationship between the three positions (a developmental progression from the primitive to the mature, from the presymbolic to the symbolic, from the pre-subjective to the subjective, from the ahistorical to the historical, etc.). At the same time, the three positions have a relationship of interactive simultaneity in that all three modes of experience represent dimensions of every human experience.

With this theoretical background, I will now clinically illustrate some of the ways in which an understanding of the three modes of generating experience informs the manner in which we as analysts listen to, understand, and attempt to talk with our patients. In particular, I shall focus on the ways in which the analyst's interventions must often be directed to the contextual level, or matrix, of transference (for example, the significance of the way the patient is thinking, talking or behaving) before it becomes possible to address other interrelated aspects of transference (for example, the unconscious symbolic meanings of what the patient is thinking, saying or enacting).

ANALYSING THE SHAPES OF THINKING AND TALKING

Ms L, a college professor in her late 30s, was referred for analysis because of chronic and intermittently paralysing anxiety and depression. Despite the fact that Ms L was highly respected by her colleagues for her teaching and research, she derived only a moderate degree of pleasure from her work. The passions in Ms L's life were painting and listening to music. As a child, she had spent a great deal of her time alone in her room, drawing, reading, and listening to music. The patient said that these activities were her life (and continued to be).

Ms L had had two previous experiences in analysis. The first had lasted approximately four years, during which time the patient felt unable to think. During that initial analysis, she said that she had held a piece of hard candy between her cheek and gums during each of her analytic hours and that the analyst had
interpreted this as the patient's wish to suck on his breast/penis. Ms L found that idea ridiculous and told the analyst so. The analyst then reportedly accused her of opposing him and the analysis at every turn. The patient viewed this interaction as paradigmatic of the tone of the entire analysis.

According to Ms L, her second analyst became quietly enraged with her and increasingly spoke to her in a contemptuous way, finally losing his temper and accusing her of being 'sadistically stubborn'. Both analysts concluded that Ms L was unanalysable and in both instances the analyses were ended unilaterally by the analyst.

Ms L began our work by saying that there was a great deal that she should fill me in on and proceeded to tell me about the emptiness and despair that consumed her life. She spoke to me as if we had been working together for years and were resuming analytic work after a weekend break. She spoke with a tone that sounded like familiarity and intimacy, but struck me as an imitation of trust. It seemed to me that this imitative trust represented an unconscious attempt to bypass the processes by which two people ordinarily develop a sense of what it is like to be with one another.

The patient made only vague references to her childhood. She presented a sketchy picture of a family consisting of a mother who was often wildly angry, a father who was emotionally remote and a sister 8 years older who seemed to have a life entirely independent of the family. One of the very few specific accounts of past experience was the patient's comment that her mother had been hospitalized each year for a period of a month or so for some medical or surgical procedure related to the mother's lifelong hypochondria.

At first, I simply listened to the flood of material, not feeling any particular pressure to interfere with the patient's efforts at telling me about herself in the way she apparently wanted to. Ms L's story was filled with torment by which I ordinarily would have been quite moved. The patient conveyed a sense of such thick hopelessness that I frequently wondered why she did not kill herself. (I strongly suspected that this thought represented a wish on my part that she would kill herself.)

Days, weeks and months went by during which I said practically nothing. (In almost every session, I wondered if I were using the idea of 'analytic restraint' as a ruse for sadistic withdrawal and retaliatory exploitation of this patient who seemed to have so little use for me.) Ms L did not complain about my silence; rather, she seemed relieved that I was not getting her off the track of all that she needed to 'fill me in on'. When I did occasionally ask for a clarification or offered an interpretation, the patient gave me the requested information (usually in a very vague form) or patiently waited for me to finish my thought before continuing with her monologue. Ms L would repeat stories almost verbatim that she had recounted many times before. I said to her that it appeared that she had no feeling that I was listening to her and that she must feel that I remembered very little, if anything of what she told me. Over time, I realized that this intervention, although partially correct, missed the point. Ms L was not talking to me and therefore it did not matter that she had recounted a story many times previously. Her stories were like a child's bedtime story that can (and should) be told and retold dozens of times. The pattern of the words and images is soothing in their utterly predictable rhythm, melody and lyrics.

Gradually, I came to realize that Ms L and I were not involved in the beginning of an analytic dialogue. Her words were not carriers of symbolic meaning; they were elements in a cotton wool insulation that she wove around herself in each meeting.

In retrospect, it seems to have been of critical importance that in the initial years of work I did not succumb
to my own wish to establish my existence in the patient's eyes by insisting that I be recognized as an analyst. Although I had not articulated this for myself at the time, I now believe that it was essential that I neither interpreted the patient's storytelling as an act of stubbornness or resistance to the analysis, nor engaged in countertransference enactments designed to allay the feelings of isolation that I was experiencing.

As time went on I attempted to talk with Ms L about what I thought I understood about the way she was talking as opposed to that which she seemed to be talking about. For example, I told her that it seemed that she felt unbearably raw when she felt blocked from the calming experience that she found in painting and listening to music. I later added that, for her, hopelessness did not seem to be an entirely bad thing; after all, it provided the incomparable peacefulness of the absence of any prospect of change. I said that I believed her when she told me that, for her, there was nothing worse than being surprised. These interventions represented attempts simply to name the patient's experience without any implication that things should be otherwise and without any reference to the idea that she might feel conflicted about these aspects of her life.

In the middle of the third year of analysis, Ms L began to tell me how well she felt I listened. This struck me as a double-edged compliment. On the one hand, I felt that I had offered Ms L a medium in which she felt that she could soothe herself, but this self-soothing was something that all her life she had provided for herself through reading, listening to music and painting. The patient's soothing herself in my presence was at least a step in the direction of object-related experience since none of the other self-soothing activities described by Ms L had ever taken place in a sustained way in the presence of another person. The self-soothing 'talk' with which the patient filled the analytic hours had made it bearable for her to continue being with me. It had provided her with an autistic shape so perfectly reliable and predictable that her dim awareness of me could be tolerated. This 'arrangement' seemed necessary for the patient and periodic efforts at interpretation demonstrated that this period of analysis should not and could not be rushed.

There was at the same time an unmistakable note of contempt in the patient's 'complimenting' me on my fine listening ability. The unstated implication was that despite the fact that I was a good listener, what I had to say was not worth very much. The angry edge of her compliment seemed to represent a more maturely object-related dimension to the transference than had existed to this point. It seemed that Ms L was in this way asking me not to allow her to remain encapsulated in her sensation-dominated world even though she felt grateful to me for not having interfered with her self-soothing activities.

Viewing Ms L's double-edged praise of me as an indicator of her psychological preparedness for my more actively 'competing' (Tustin, 1980) with her system of autistic-contiguous relationships, I decided to address, much more directly than I had previously, the nature of the sensory-dominated solipsistic world in which the patient wrapped herself. I said to her that in the years that we had been working together she had both told me about and demonstrated to me the ways that she had of not living in the world. She had from early childhood developed the capacity to collapse into herself like a star that has imploded to the size of a ping-pong ball. Her immersion in the sensations, rhythms and ecstasies of art and music had consumed almost every waking moment of her life outside of her work and had become substitutes for almost every other form of experience. I added that, in the analysis, her storytelling served as a way of not talking to me, of not being in the room with me. The stories were like lullabies that she sang to herself.

The patient listened and was silent for about a minute. She then went on talking in a way that at first appeared to be a response to what I had said, but within moments revealed itself to be the beginning of the repetition of a story about a childhood event that she had recounted many times before. In the following
meeting, the patient talked as usual for about twenty minutes before saying that she was furious that I was so insensitive as to tell her repetitively something she already knew. Did I think that she was stupid? Did I really need to be so intrusive in my comments? I said to her that it seemed that she had not liked what I had said, but was not talking to me about what had upset her about my comments. The patient then returned to telling still another story about her childhood that had the superficial appearance of being a response to my intervention. I interrupted the story (since there were no pauses that allowed a dialogue to take place) and said that I thought that she had been upset by what I had just said and that it was comforting to her to return to a form of storytelling that served to soothe her like a familiar lullaby. The lyrics and melody were fully known and predictable and would never change. The same could not be said of me and I thought that that fact both frightened her and infuriated her.

Over the succeeding weeks, the patient alternated between railing at me about my insensitivity and resuming her storytelling. During this period, I said to Ms L that I thought that she was enraged at me for having tampered with the things most sacred to her: her feelings about her art work and her love of music.

There then followed a period of analysis in which the patient made no reference whatever to the events just described. It was as if a storm had passed leaving no evidence of its having occurred. I commented on the way in which a segment of our recent history had been expunged in a '1984-like way'. The patient said that she knew that she was doing that and explained that she was an expert at that game. She told me how powerful a weapon that ability had been in her relationship with the man with whom she had lived for several years. He would stew after an argument while she could 'turn off the light and immediately fall into a deep, dreamless sleep'. The next morning, it would take her a moment to figure out why her boyfriend was not talking to her. (I was more than a little surprised to hear that she had lived with a man, but decided to accept her gift of this new information without making her acknowledge the fact that she had given something to me.)

Over the following year of analysis, Ms L's 'storytelling' gave way to talk that included an expanded use of metaphor. For the first time she seemed to be using language in an attempt to say something to me; there were aspects of her life that she wanted me to know about. For instance, she talked about the role that 'spinning' had played in her life beginning in childhood and lasting until her early twenties. This spinning was a sensation that she could feel through her body: 'it was like dizziness, but it wasn't actual dizziness'. This was an extension of actual spinning that she had done as a child when she was alone. In both the physical and psychological forms of spinning she could create a state of mind in which she felt insulated not only from people, but from thoughts. She used the capacity to create this somato-psychic state during the very frequent occasions when she wanted to be alone and could not physically get away from other people. She developed the capacity to learn what she had to learn in school very quickly so that she could return to her psychological spinning while sitting in class.

In the following years of analysis, the patient's ability to talk to me waxed and waned depending upon the degree of anxiety she was experiencing. However, it was usually possible for the patient and me to identify the nature of the transference feeling that had precipitated her withdrawal into storytelling or other forms of defence against the feeling of being alive in the room with me. In this way the analytic work increasingly involved the interpretation of the way in which shifts in the matrix of transference were related to the emergence of specific object-related transference thoughts and feelings (e.g. sexual and aggressive wishes and fears).

In summary, language was initially used by Ms L not for the purpose of thinking and making herself understood. Rather, language was used almost entirely as a sensory medium in which the patient could wrap herself. Speech had become the antithesis of communicative discourse. The interpretation of the
content of the patient's stories proved futile. Instead, interventions were largely descriptive of the patient's experience and did not attempt to identify intrapsychic conflicts. (There was very little of an integrated self capable of entering into and maintaining the psychic tension involved in internal conflict.) When the patient gave indirect indication of her preparedness for a disruption of (competition with) her reliance on autistic-contiguous forms of defensive insulation, Ms L's use of language in the service of not talking was interpreted.

Interpretations increasingly focused on the relationship between the context of transference (the way the patient was thinking, feeling, talking, and so on) and the affective content of the transference (the anxiety generated as a result of the enactment of an aspect of the patient's internal object world on the analytic stage).

**ANALYSING 'DISSOLVING' THOUGHTS**

A 25-year-old-graduate student, Mr D, began analysis saying that he was unable to study or to work because of intense feelings of anxiety and worthlessness. He also suffered from a longstanding eating disorder of an anorectic sort. Discussion of feelings about food, dieting, exercise, etc. was conspicuously absent during the first months of analytic work. Mr D at times found it extremely difficult to maintain a line of thought and would find himself finishing a sentence on a topic that was unrelated to the beginning of the sentence. Over time, the patient and I came to refer to this as a form of 'dissolving' psychologically. At these moments he felt as if he had almost no identity and did not feel as if he were a person who could think, much less speak his thoughts in a voice that felt like his own. Mr D used paranoid ideation as a way of grounding himself somewhere: at least if he were convinced that someone hated him and was plotting against him, he had some sense of a self perceiving and evaluating what was happening to him. Not surprisingly, in the course of analysis, Mr D slipped in and out of feelings of extreme distrust of me and feelings of being attacked by me.

In the second half of the first year of analysis,

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2 In interpreting the interplay between the context and content of transference, the analyst attempts to direct the patient's attention to the moment of substitution of one form of thinking, feeling and behaving, for another. There is an assumption, often articulated by the analyst in his interpretation, that the patient has experienced in the analytic situation the beginnings of thoughts, feelings and/or sensations that were so disturbing as to lead him defensively to alter his way of thinking, feeling, talking, etc. That is, the patient alters his way of generating experience in such a way that one or another of the dimensions of experience (the autistic-contiguous, the paranoid-schizoid or the depressive) defensively excludes the others (cf. Ogden, 1985), (1988), (1989a), (1989b). This alteration in the way experience is being generated is in part perceived by the analyst through his monitoring of shifts in the countertransference. The experience of being with the patient often undergoes a subtle but discernible change resulting from an intersubjective shift in the balance of modes contributing to the creation of transference-countertransference experience.

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it was with great caution that the patient tentatively, and very indirectly, broached the topic of food and eating. Unlike his uncertainty about almost every other aspect of his life, the patient held a strong conviction that his moods were powerfully shaped by the foods that he ate. Each food group was felt to
have a specific impact on him. For example, sugars of all sorts including those in fruits and milk made him 'manicky' and wildly anxious; fats immobilized him and made him feel lethargic, hopeless and depressed; moderate amounts of protein and grain made him feel stable and level-headed.

It was evident how delicate a subject the topics of eating and food were for this patient and therefore I refrained from commenting on the content of the patient's ideas. I decided instead to ask the patient if he was aware of how frightened he seemed to be of my saying anything to him when he talked about food. (Even this intervention proved to be too heavily directed at phantasy content and insufficiently addressed to the way the patient was thinking.) He responded by saying that even though I had not said anything yet, he knew what I was thinking. He was sure that I, like all other doctors, viewed his ideas about the effects that food had on him as 'psychotic delusions'. (Both of the patient's parents were psychiatrists who openly discussed the patient's behaviour using diagnostic terms and regularly interpreted the unconscious meaning of his thoughts and behaviour.) Mr D became intensely angry with me and fearful of me at this point and vowed never again to trust me with any of his thoughts about food. I said to Mr D that any mention that I might make, and perhaps any thoughts that I might have about food, felt to the patient as if I were making his ideas and feelings about food a 'psychological issue' and that was tantamount to my attempting to drive him crazy. I went on to say that I understood that there were few enough things in his life about which he felt that he could trust his perceptions. For me to draw into question in any way what he felt he knew about his response to food would be as basic an assault on his sanity as my calling into question the veracity of his perception that this thing is a chair or that thing is a couch.

Mr D was relieved by this intervention, not because it involved reassurance that painful mental content would not be addressed. (Patients are almost always angry and disappointed when the analyst unconsciously assures them that an aspect of their psychopathology will not be treated.) Rather, the patient experienced the intervention as an acknowledgement of his right and his capacity to name (and misname if he chose) his own bodily states without having this self-defining process co-opted by me.

The patient had reported that in a previous analysis, the analyst had acted as if she knew what the patient was feeling better than the patient himself did. Under circumstances when the analyst consciously or unconsciously conducts himself as if he believes that he knows the patient's experience better than the patient does, there ceases to be a recognition of the existence of two people in the consulting room; instead, only the analyst and his conception of the patient's experience remain. This almost always represents a repetition of an early childhood experience (of the patient and/or the analyst) wherein the mother unconsciously saw in her infant only the aspects of herself that she projected into him.

I view the intervention in which I discussed the patient's fear that I was driving him crazy as a necessary interpretation of the context of meaning that must precede the interpretation of psychological content (e.g. the conflicted meanings that food held for Mr D). The aspect of the patient's experience that had to be addressed before all else was the idea that his thinking was functioning in the service of an attempt to hold on to a dissolving sense of self. His thoughts were being generated in order to preserve what little there was remaining of his sense that he existed. The concreteness of Mr D's thinking served to make his thoughts feel more real and less likely to be stolen or taken over by me. As the patient looked back on this period, he said that it had felt as if his thoughts had become 'hardened' and in that state could be more easily 'held on to'. He experienced all ambiguity of meaning as extremely frightening since he would feel as if he were 'slipping and sliding over the surface of very thin ice'.

It was possible over time to understand the way in which thinking in a concrete way represented an unconscious attempt to ward off the threat of 'dissolving', 'falling', 'losing a thought', etc. Further, it was possible to observe and to interpret the way in which this threat arose in the
context of a (maternal transference) experience of me as someone so 'adept' at interpreting Mr D's experience that only I knew what he was thinking and feeling. Much later, the patient became aware that he had originally chosen me as his analyst in part because he had hoped that I would be so perceptive as to be able to know his thoughts before he did. This represented a wish that he might become able to feel alive and capable of thinking and working by getting me to live and think for him. At the same time, the patient struggled against such wishes because of a conviction that a submission of this sort would be the end of him. He was afraid that once such a submission had occurred, he would never be able to recover the fragments of his own perceptions that provided his only connexion with his flimsy sense of self.

To summarize, in fragments of analytic work discussed here, it was necessary to analyse in the transference the function of the way the patient was thinking before the content of that thought process became accessible for analysis. After an initial, poorly timed intervention, the interpretive focus was shifted to the way in which the patient's thinking served to help him preserve his fragile and ever-eroding sense of self.

ANALYSING SEXUAL THINGS-IN-THEMSELVES

Ms R, a 25-year-old junior high school teacher, began analysis because of intense anxiety of a diffuse nature. She had had a severe anxiety attack while teaching and was afraid that further attacks would follow and result in her losing her job. In the initial meetings, the patient presented herself in a halting, self-conscious and somewhat prudish manner. She was an attractive woman, but dressed and wore her hair in a way that conveyed a sense of barrenness. Ms R said that she had had 'relationships' with men, but she was vague about this and left it quite unclear as to what, if any, sexual experiences she had had.

In the course of Ms R's giving me an account of the people in her life who were important to her, I was struck by her sense of the brittleness of the ties that existed between people. Longstanding friendships could be destroyed if one were to say the wrong thing at the wrong time; a friend's father had had a heart attack within days of his daughter's informing him of her engagement to marry; her own father had been abruptly fired from his job after a dispute with his boss.

Several weeks into the analysis, the patient announced that it was necessary for her to discontinue analysis for financial reasons. There was no convincing evidence that financial difficulty accounted for the patient's precipitous flight. I asked her what else she thought might be involved in her decision. After reflexively saying that that was all that was involved, she admitted that she had felt increasingly hopeless about the possibility of getting anything out of analysis.

I said to her that she had made it clear in the weeks that we had been meeting that words and thoughts were deadly serious things that should never for a moment be treated as 'just talk'. People could be badly hurt if they were not extremely careful about what they said to others and what others said to them. She turned on the couch and looked at me in a way that reflected the fact that she was intensely interested in this subject and was surprised that I understood the enormous power of words.

Ms R said that in childhood she could not understand how other children could recite nursery rhymes about heads being smashed open (e.g. 'Humpty Dumpty' and 'Jack and Jill') about father's dying ('My country 'tis of thee') and spiders terrifying children ('Little Miss Muffet') without being as terrified as she had been. She went on to talk about the way in which she had often been deeply hurt because she had taken people at their word. If a man at

3 The most important of Freud's (1915) three major theories of schizophrenia involved a similar emphasis
on the patient's formation of 'thing presentations' (p. 203), not for the purpose of internal communication or for the purpose of trial action, but for the purpose of using thinking (the creation of thing presentations) as an attempt to hold on to or regain a connexion with the external world. In other words, schizophrenic thinking (the process of generating thing presentations) was conceived of as the patient's attempt to retain or regain his sanity.

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a party were to tell her that he would call her, she would treat this as a solemn promise. She said that in first grade when her teacher told the class that they would have 'show and tell' each morning, she became extremely anxious fearing that she would have to reveal her secrets or perhaps even take off her clothes. Moreover, she was not certain whether the teacher had said 'show' or 'shower'.

I then said that I wondered if she felt that analysis involved revealing herself to me and that she had begun to despair that if she were not willing or able literally to bare herself to me, she would get nothing out of it. On the other hand, it would be devastatingly humiliating if she were to force herself to reveal herself to me.

The patient cried and told me that in college she had read that Freud believed that ultimately everything was sexual. She asked me if I thought that everything had a sexual meaning. I told her that that would mean that she and I would be continually engaging in 'dirty talk'. She agreed and said that she had no wish whatever to do that to me or for me to do that to her. This interchange led to a decrease in Ms R's level of anxiety sufficient for her to continue in analysis.

It is not possible in this brief discussion to offer more than a schematic overview of the unfolding of the analytic process. In what follows I shall attempt to illustrate something of the movement from the analysis of the matrix of transference (concretely elaborated in the experience of talking as sexual action) to the analysis of the content of unconscious phantasy that is symbolically elaborated (as thoughts and feelings) in the transference. In the succeeding months of analysis, the patient discussed her childhood experience in considerably greater detail than she had previously. Ms R said that she could not recall ever seeing her parents argue and yet the tension between them was so great that she would become nauseated and develop headaches when she spent an extended length of time with the two of them. Each seemed to be a master of the 'vicious innuendo' and 'looks that eviscerated'. The patient described chronic insomnia beginning at about the age of 3 or 4 which continued to the present. She cried as she described the intense feelings of loneliness that she felt as she lay in bed unable to sleep.

As this material was being presented, Ms R became increasingly anxious and developed an intensely held conviction that I was deriving great pleasure from the power I held over her as her analyst. She said that she found it very difficult to listen to anything I said to her because all she could focus on was the smugness that she heard in my voice. As the analysis proceeded, the patient's relentless complaints about my 'swelled head' and contemptuous tone of voice began to feel increasingly wearing and abrasive and I experienced a profound sense of disconnectedness from her. Ms R seemed obsessed with the idea that I was pushing her around and seemed to take pleasure in rendering worthless anything I had to say by reflexively responding with an accusation of this sort. I commented to the patient on several occasions that she seemed untiring in her attempt to goad me into a verbal attack on her. I added that I thought that such an attack would make her feel less anxious and lonely. Over time these developments in the transference-countertransference (as well as Ms R's series of dreams involving her watching 'sweaty, foul-smelling' street gangs wildly yelling and shooting at one another) led me increasingly to suspect that Ms R had experienced the tension between her parents (and the process of talking with me) as a violent and confusing sexual/aggressive act. Words, tone of voice, innuendo, looks, etc. seemed to have been unconsciously experienced in a very concrete way as sexual parts of each of her parents (and of the two of us) being used to bash, enter into, injure, excite, tantalize, enrapture and drive away the other. At the same time, not to be included in this form of relatedness led her to feel unbearably isolated.
In a meeting that occurred in this period of analysis, I made the following comment in response to the patient's again saying, 'You don't have to bully me'. I said that she was right, I did not have to talk to her in any particular way, but I thought that her experience of me as bullying meant to her that we were important enough to one another to become locked in battle. I later commented that I did not think that she could always tell what was hateful and what was loving about the bullying that she felt was going on between us. The patient, in a singularly uncharacteristic way, responded with reflective silence instead of a further round of accusation. This marked the beginning of a period of analysis where it became increasingly possible for Ms R to talk about feelings and ideas as opposed to enacting ideas and feelings in the form of talk.

It was not until the third year of analytic work that the patient began to discuss sexual feelings and fantasies directly. This followed the analysis of highly anxiety-laden transference fantasies involving the idea that I had a harem of female students and patients whom I treated in a callous and cavalier manner. With intense shame, Ms R told me in small bits and pieces over the course of almost a year, that from the time that she was 5 years old (and continuing to the present) she had masturbated 2 to 3 times a day. Ms R masturbated by holding a pillow or blanket between her legs. The central masturbatory fantasy (which had not changed over this period of twenty years) involved her being a member of a harem of women whose master ordered the women to have sex with him. The master was occasionally experienced as kind, but usually was pictured as impersonal, sadistic, and demanding absolute submission of the patient and the other women. Nonetheless, she felt 'nothing but blind devotion and loyalty' to this man and to the other women. This form of compulsive masturbation and the phantasies associated with it were understood as serving a number of critically important psychological functions. At its most primitive level, this activity seemed to serve a self-soothing and self-defining function. The patient, in the face of the experience of extreme isolation from early on, had constructed a sensation-dominated form of relatedness (to an autistic shape) through which she attempted to maintain the fragile coherence of self that she had achieved.

At the same time, Ms R used the phantasy of the harem as a way of constructing an internal object family for herself. The patient had invented a version of the Oedipus complex that was based on the wish for integration and inclusion (albeit at the cost of personal identity and mutual recognition). Ambivalence and parricidal wishes were regressively transformed into blind devotion to an omnipotent object; rivalry and recognition of generational difference were converted into the ties between siblings and narcissistic twinship.

To conclude, in the very early stages of the analysis, talking about sex with me was experienced by the patient as equivalent to having sex with me. The analysis itself was experienced as a sexual enactment rather than as an arena in which sexual thoughts and feelings might be experienced, discussed, and understood. It was therefore essential to talk about the way in which talking was experienced as sexual enactment (i.e. to analyse the contextual level of transference) before addressing other levels of transference meaning. As a result of the analysis of the heavily paranoid-schizoid contextual level of transference (talking as a sexual/aggressive event), the patient was eventually able to achieve a shift towards an increasingly depressive mode of generating experience. Her sexual anxiety did not disappear; rather, it was experienced differently. What had formerly been the experience of frightening sexual things in themselves (hurled about in the form of words) became frightening and confusing sexual and aggressive feelings and ideas that did not immediately have to be deflected through the use of concrete word barriers (in the form of defensive accusations).

CONCLUDING COMMENTS
The matrix of transference can be thought of as the intersubjective correlate (created in the analytic setting) of the psychic space within which the patient lives. The transference matrix reflects the interplay of fundamental modes of structuring experience (the autistic-contiguous, paranoid-schizoid, and the depressive) that together make up the distinctive quality of the experiential context within which the patient creates psychic content. This concept addresses

4 In analytic work with patients functioning in a predominantly paranoid-schizoid mode, one must keep in mind that the analyst's attempt to explore the patient's fear of talking about sex (without first analysing the contextual level of transference) is regularly heard as a seductive and coercive inquiry into the question of why the patient is refusing to have sex with the analyst. The combination of fear and excitement that the patient experiences under such circumstances often leads to a flight from analysis or to other forms of acting out.

not only the events occurring on the analytic stage, but the states of being determining the nature of the ways in which thoughts, feelings and behaviour are created, experienced and interpreted by the patient.

The analysand does not simply speak to the analyst (or himself) about the ways in which he creates experience; rather, he contributes to an intersubjective construction within the analytic setting that incorporates in its shape and design the nature of the psychic space within which the patient lives (or fails to come to life). Invariably, the analyst unconsciously participates in the creation of the intersubjective construction within the analytic setting. It is in part through this avenue (i.e. through countertransference analysis) that the analyst gains access to the nature of the states of being comprising the matrix of the patient's internal world.

**SUMMARY**

In this paper, the background experiential states forming the matrix of transference are discussed in terms of the interplay of three modes of generating experience: the autistic-contiguous, the paranoid-schizoid and the depressive. Portions of three analyses are discussed in an effort to illustrate clinically some of the ways in which analytic technique is shaped by an understanding of the predominant mode or modes of experience forming the context of the transference-countertransference at any given moment. There is a focus on the ways in which the analyst's interventions must often be directed to the contextual level, or matrix, of transference (for example, the significance of the way the patient is thinking, talking or behaving) before it becomes possible to address other interrelated aspects of transference (for example, the unconscious symbolic meanings of what the patient is thinking, saying or enacting).

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