Experesive Uses of the COUNTERTRANSFERENCE—Notes to the Patient from Oneself

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AN ANALYST'S COUNTERTRANSFERENCE IS A CONTINUOUS internal response to the presence of an analysand that necessitates a different kind of attentiveness of the analyst's part from that which he gives the patient. Although many patients create through the transference an environment that is favorable to the analyst's good enough state of mind, we are more mindful these days of those patients who represent their existence through the other's moods and thoughts, and, such a countertransference will compel the analyst to take himself as the object of interest, insight, and quite possibly of "cure".

Like many clinicians these days I entertain the possibility that for differing reasons and in varied ways analysands recreate 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. 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 hyperbolize that
child they were in the transference, tentatively looking to see if we become the mad parent.

I am not going to focus in this paper, 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 toward some interpersonal environment; but analyses rarely proceed with such clarity, the clinician knowing in advance 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 the 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 distress into the analyst. This process is already well known to us and although I do not intend to elaborate how we understand projective identification, I will discuss how the analyst must become a transformational object (Bollas, 1979).

It is my view that the analyst must find some appropriate means to selectively express some of his subjective states of mind, even when he does not know what it means. Why I believe this is necessary and how I think we can do this will be the object of the paper. I think it is crucial that clinicians find a way to make their subjective states available to the patient and to themselves as objects of the analysis. I also believe that on rare but significant occasions the analyst may analyze in the presence of the patient his experience as the object of the patient's transference (Tauber, 1954).

Countertransference Readiness

Alongside the analyst's "freely and evenly hovering attention which enables the analyst to listen simultaneously on many levels," writes Paula Heimann (1960), "he needs a freely roused emotional sensibility so as to perceive and follow closely his patient's emotional movements and unconscious phantasies" (p. 10). If the analyst regards the emergence within himself of feelings, fantasies, passingly inappropriate 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 would ironically enough 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, 1912p. 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), inside which the patient can live an infantile life anew without the troublesome impingement of the clinician's judgements. From the psychoanalyst's point of view, however, once with a patient, one's neutrality functions as a dream screen (Lewin, 1946); it is there, but only as an area within the analyst that registers unneutral feelings, fantasies, 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 hunches, feeling states, passing images, fantasies, and imagined interpretive interventions. Interestingly, 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 ourself. 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**

The deliberate allowance for and facilitation of the analyst's internal mental processes, as a complementary source of free associative material to that provided by the patient, suggests that it is in keeping with the spirit of psychoanalysis, as that discipline that 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.

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 were I to close down this internal space and replace it with some notion of absolute
mental neutrality or the idea of scientific detachment. Indeed, by maintaining an internal space for the reception of the patient's transference the analyst is more likely to fulfill the intent of Freud's concept of the analyst's mirror function. Although I think Freud's metaphor is somewhat unfortunate in that as a mirror has no feelings it can not register the emotional intent of an act committed in front of it, the analyst is able to facilitate the patient's transference intent the more because he is alive, not inanimate, and it is his aliveness that registers the patient's transference communication.

What the analyst feels, imagines, and thinks to himself while with the patient may be at any one moment a specific element of the patient's psychic life that is projectively identified by the analysand, but I prefer to use Giovacchini's (1979) concept of externalization to classify that total creation by the patient of an environment in which both patient and analyst live a "life" together. If a projective identification creates a projective counteridentification (Grinberg, 1979), and I am certain we can all think of many examples in which what we think or feel is created by a specific mental action on the patient's part, it is not true to characterize the countertransference as solely due to this process of projective identification.

Patients create environments. Each environment is idiomatic and therefore unique. The analyst is invited, as we know, to fill 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 in to the patient's environmental idiom and for considerable stretches of time, we do not know who we are, what function we are meant to fulfill, or where we are going. Neither do we 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 transference responses to life within the patient's environment. This inevitable, everpresent, and necessary uncertainty about why we feel as we do gives to our private on going consideration of the countertransference a certain humility and responsibility.

The most ordinary countertransference state is a not knowing yet an experiencing one. I know that I am in the process of experiencing something, but I do not as yet know what is 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. But I find that to discover 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 in, these features of the countertransference take months and years to see. 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.

Provided the analyst can tolerate the necessary loss of his personal sense of identity within the clinical situation I think he is more able to achieve that necessary process identity which allows him to receive and register the patient's transferences. By permitting himself to be used as an object (Winnicott, 1974) 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, thus hearing from 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 use us, we may turn to the countertransference and ask of ourselves: how do we feel used?

We are more often than not made use of through our affects. The creation of an affect within us is use. 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 toward 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 analyzed and possesses confidence in his own ego functioning and object relatedness then I think it is more likely that he will have a necessary capacity for generative countertransference regression within the session. We know that the analytic space and process facilitates 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 rather situationally ill, in so far as his receptivity to the reliving of the patient's transference will inevitably mean that the patient's representation of disturbed bits of the mother, or the father, or elements of the infant self, will be utilized 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 where is the patient? In my view, much of the work of analysis will have to take place within the analyst (Feiner, 1979), as it is the analyst who through his situational illness is that 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, however, in treating myself I am actually attending to the patient, as 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 analyzing 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 truly free associative process takes place within the analyst, and the clinician must find some way to report his internal processes thereby linking the patient with something that he has lost in himself and enabling him to engage more authentically with the free associative process.

One of the difficulties is how to make material available to the patient when the analyst may not as yet know what the unconscious meaning is. 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, such an analysis would go nowhere.

The analyst must be prepared to be subjective 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 (1974) 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 will illustrate 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 to 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 other versions of the self, the official version.

If the psychoanalyst has a particular kind of relation to his own interpretations as objects bearing potential truth, and possessing thereby a capacity to release the patient toward new self experiences, then it is possible to disclose one's subjective states of mind to a patient. 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", or "I am thinking that", or "I have a hunch about something", 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 talking about, 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 cornered by me 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 as yet 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 through analyzing. As so much of that which is now days experienced is within the analyst, one of our emerging technical difficulties is how to give back to the patient either what he has lost, or bring those parts of himself to his attention that he may never have known.

**Self Relating in the Analyst**

Each of us is perpetually engaged in a complex relationship to the self as an object (Bollas, 1982) 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, if I am 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, thats not it, I can't quite find what I want to say" or, 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—not unlike the patient in the analysis—and another part of me functioning as the analyst. I do this because I think it can be very difficult to actually put into words
what I believe a patient's mood to be, and I make my own effort to articulate
and struggle with the problem of describing the psychological intent of the
patient's transference an open problem, one in which I use my own subjective
registrations of the situation and attempt to find words to represent them, and
then, inevitably at some point, I proceed to analyze the situation. This rather
open struggle to put forth verbal articulations of one's own subjective states,
rather than say organized interpretations, is an important feature of my
technique with the more severely disturbed patient, as in my view, I am
gradually putting out in that potential space between us those associations that
are moving freely within me but that 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
articulation the patient will join in and use his or her own verbal
representations to speak elements of himself. And of course it is part of the
analysand's total recognition of this process that he is 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.
By verbalizing my own subjective states I am of course proceeding to make
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 with severely disturbed patients. In particular, I have
found it indispensable in utilizing countertransference states even though in
doing so I am not fully conscious of what my internal state means. I am now
referring to those sorts of feelings an analyst has in working with a patient
which can be described as hunches or more accurately as senses. 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 part of the person's psychical movement in a session which seems to work from the core of the self outward as in a spontaneous gesture.

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 by saying "I sense you have moved away from the completion of a feeling; you seem to be saying …", I am endeavoring 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 non instinctual 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 of subsequent associations on the patient's part which complete the developing feeling, thought, or ego capacity, which had up till then been lost, discarded, or perhaps unappreciated by the patient.

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 objectify in language his own subjective state, and he may very well be speaking up for x (that which it means) before he knows what x is. In other words, 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 toward 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, toward 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, and like the mother the analyst is seeking out and relating to the unconscious gestures in his patient; he is, that is, finding and supporting the infant speech in the analysand and doing so, ironically, by speaking up for his own non verbal sensations.

In so doing, the analyst, not unlike the mother, mirrors the infant speech; he speaks back to the patient through the verbal representation of the analysand's 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 "oooh" 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 analysts responsible and comfortable rootedness in subjective experience. The assessment of that which is true in the patient springs not inevitably from the rather too 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

Perhaps it is clear how I make an indirect use of my countertransference. To do so I establish a means for the expression of my subjective states and now and then I put verbal representations of such 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. It is fair to say that this constitutes an Other source of freely associated material and 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 movement of the as yet inarticulate element of psychic life; once the patient's self state is verbally represented then it can be analyzed. Finally, then, by indirect use of the countertransference I mean those occasions when the analyst becomes witness to his own feeling state and may in the presence of the patient offer this feeling state for consideration.

By direct use of the countertransference I mean that quite rare
occasion, but 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 persecuting 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 more clearly how one feels
to be the object of the patient's transference.

If telling a patient what one senses about them in the session is an indirect
use of the countertransference, the describing how the analyst feels about
being that which he is as the patient's object is a direct use of the
countertransference.

Before I proceed to illustrate my thinking with clinical examples I must
stress that I am not referring at any point, with either an indirect or direct use
of the countertransference, to the clinician's thoughtless discharge of affect.
As in any analytic intervention, it is exceedingly important to consider
whether the patient can use such an intervention, and this is why I place so
much emphasis on the gradual presentation over time to the analysand of the
analyst's sense of the situation as 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 would be only in the interests of the analyst's self cure
were that the only criteria. There are patients to whom one could not directly
express one's experience as the object and this must be accepted.

Clinical Examples

I

When Helen, a woman in her mid twenties, began her analysis with me I
found myself in a curious position. 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 this stranger (the analyst) 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 somewhat accurate.

But her self interruptions and long pauses continued. I knew I had not fully
understood the situation. It was not simply due to initial anxiety in the
transference: i.e. "who is this man and how do I talk to him?"

I did know from her that several years before 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. So I considered it a possibility that she paused
because she was waiting for me to translate her into 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, and I rather expected her to get on
with telling me about herself without such disconcerting pauses.

No such luck. Instead I found the situation really quite unchanged, so I
knew that this feature of her character was much deeper than I had reckoned,
and was not a situational reaction either 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 that 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 what I felt irritated on occasions, but equally, I felt there was no
way in which to utilize this irritation toward 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
second 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 sense that most patients

- 13 -
assist the analyst in considering them, but, 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 did decide that the
material that was 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, and I knew I would have to find some way to make the
material available to her.

Thus, 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 rather 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, as it was not occasioned by anxiety, and often she would
experience a kind of despair about being inside this habit, so she would often
wonder whether there was any point in continuing with her verbalizations.

In speaking up for that situation I found myself in I was also aware of my
own personal relief. No analyst should only interpret 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 of how distracted and otherworldly her mother was, and how, as a child, the mother could only relate to a small portion of her, 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 self interruptions 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, nonetheless, absented herself from children's lives for a number of reasons, and left each of her several children severely confused.

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 hyperbolization of a phenomenon that is almost an invitation for someone to challenge its veracity. Thus even though he acted very coldly and remotely in the sessions I found myself disbelieving this. I sensed that this 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 atomize one of my interpretations into its latent intellectual assumptions and he would chortle on about implicit logics of mine: class issues, cultural assumptions, feminist or antifeminist elements, residual Americanisms, and a multitude of bourgeois interests.

I never felt, however, really insulted or really cross with him. Frustrated yes. Irritated at his investment in some kind of false relating at a manifest level: 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 the analyst into an interpretation, so he could have the pleasure of destroying it—I knew that some of this obsessionality was a tease and that some of his unconscious love was being expressed through homosexual libido.

His obsessional preoccupations and his homosexual feelings were taken up in the analysis and occupied much of the analytic work during his first year of treatment. Both his obsessionality and his unconscious homosexual longings were, however, compensatory dispositions, alternate 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, as I have said, 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 detail his life to me and whenever I had misunderstood something he said, he sensed when 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 lead me to realize this was an expression of his unconscious love.

There came a point in his analysis when I considered it necessary to utilize my subjective grasp of the situation to stand up for 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 would say to 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 often he would extol the virtues of rational and objective thought, but he would do so 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.

- 16 -
Sometimes he would reflect on some event in the world that had caused people great concern, one such moment being the assassination attempt on the Pope. "I can't for the life of me understand why people get so upset about something like this," he says to me "I think I have to ask people about this so I can understand. Why do you think I don't understand?" He says this to me in a puzzled pseudo quizzical way, but professionally delivered with the expertise of many years experience in appearing to have no feelings. When he asked me this "question" I replied very simply, I said: "nonsense." He laughed and said what did I mean "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" but this would bring him out of his false self coldness into relatedness; he would laugh and clearly be relieved in some part of himself that I saw through his pretences. When he would snicker and ask 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 did not equalize other ways of knowing through the production of "evidence".

The trauma in Paul's early object relationships 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 eroticized efforts to find a father (and also to dismiss him) and his coldly obsessional false self was his unconscious reconstruction of his father's character. I knew, therefore, 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.

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 to speak 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."

In a sort of half hearted way he proceeded to scoff at my remark but I could tell from his response that he wanted me to proceed 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 analyze how he was dosing me with that cold father he had and how I was in that 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 true uncertainty about whether I could withstand the situation.

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 analyzed people who do quite rightly make such statements, but such persons demonstrate this fact through their behavior in the sessions in one way or another. 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 describe 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 patient 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 presented immediately with a dilemma, however, as I thought that to continue to analyze her material without conveying to her my sense that this material was strangely untrue, I felt, to her actual self, would be to sustain a false analysis. So I told her that I was puzzling over something, and, as long as she understood that I was making my sense of something available only to further understanding of her, and bearing in mind that I might well be wrong, I told her that she just did not seem to be the wrecked person that she claims she is. Now 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 something of the seemingly irrational affective element of the session and subsequent sessions: where did it come from and what did this comment mean?

Meanwhile I continued to feel as I did even more so. It was not only that Joyce reported professional accomplishments that in themselves refuted her notion of incompetence, but her lively presence in the session was transference evidence, from my point of view, of the presence of true self activity. When she would talk about other people in her life or certain situations she did so with humor and mental acuity and I found that I enjoyed her presence, but whenever she would turn her narratives to herself as an object she would lower her voice and proceed to lambast herself and list her latest failures, all this contextualised in the wretched climate of living with no sense of self.

I shall not list all of the psychodynamic considerations and possible transference explanations I thought about during these early months of her analysis, as this would take up too much space. I did know from her that her early relation to her father had been very good and that he had fairly worshiped her, but that when she was about six years old he withdrew because of ill health and she receded into herself a bit at that time, although she spent quite a lot of her time looking after her father, in terms of providing him with psychological support.
It became clear that she had lost him when she was about six and perhaps more to the point for her, she lost his relation (and her own) to her as an ideal self. I interpreted this and analyzed her presentation to me of the so called depressed self and absence of self as expressions 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, her own self, was part of 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, but in that moment I think it is more to the point to say that it creates the other relation to her father, as she nurses those objects (including herself) in her life 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 wreckage 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 opposite and the matter is further complicated by the reality of genuine health and ego capacity in her, but I continued to feel uneasy about the analysis. She was absenting herself but in a most subtle manner and I certainly 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 unfindable. 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 said: "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 that which I considered essential material into some space where both myself and the analysand 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, 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 lurched 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 said: "Perhaps what I have said has made you feel guilty which was not my intent, 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", which she stressed several times. I then proceeded to say "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 proceeding to make his last interpretation by her reaction to my first intervention when she protested vehemently. The protest was much 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 that which she was concealing was 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, and she regarded my firmness and non traumatic sense of conviction as the most important factors in her eventually entrusting me with her love towards myself and those loving memories she had of her father.

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 that he is a person 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 in all black outfits. Over the years, however, I have managed to find a way to live inside the environment he creates and I have done so by analyzing him even when he threatened to murder me if I didn't shut up, and 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." Such comments I delivered with vigor and presence but not hostility and, over time, he gradually began to need this kind of response in 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 now, however, came after some three years of analysis. Of course I had had many occasions to analyze his grandiosity, his omnipotence, and his utilization of saintly 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 the other in every session. That was that he would proceed to tell me something about himself, let's say some observation of an action on the previous day, and when I would take 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 (for me) days he would deny having said anything at all. My interpretations of this also varied according to his ability to make use of understanding on any one occasion, but I stressed his anxiety and his need to control the situation and his despair that I did not live inside him, so having to tell me something about himself, which implied my separateness, was very distressing. 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 analyzing something without changing the details and I noted to myself that the material he reported was more specific and less of a kind of abstract lecture on himself which he was prone to do 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 when he came to his session he completely re-edited Monday's material and wiped out our Tuesday session and eradicated that sense that I had that possibly we were beginning to work together. For some fifteen minutes into the session I recall 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 goddamned session and don't bother to find a way through to him." My response shocked and bothered me, for, although I had often felt very angry with him and futile I had never reached this point, for in my countertransference I was clearly feeling some rather dreadful loss.

I decided against proceeding along my ordinary analytic line with him, that is interpreting to him 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 although he is an analytically
interesting person, I thought he would be one of those sorts of unfortunate
people who spends a lifetime in analysis but is no different for it.

Thus I 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, as I was clearly
struggling to break through something in myself as well. I said, "George. Stop
talking for a minute. I want to say something to you." (He could manically
lecture on anything for a full session, so I knew I would have to interrupt him
to get to him). "I am aware of feeling utterly hopeless in myself 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 possibly it might help us to understand this situation a bit better." As
much as what I had said up to this point was effective, I think my tone of
voice, which I find impossible to describe now, was that which 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" very quietly, so much so 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 that
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
rather long 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 I felt at the same time that I had
also stood up for the patient as well.

Now I should add that I knew a great deal about his early childhood and
that our reconstruction of his life had played quite a role in his analysis. 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. Essentially she had to leave him not because she hated him or what have you but because she was depressed and could only find narcissistic replenishment in her work. George had never established a relation to his father who was kindly but remote and who disliked the role of being a father. At six George was sent to boarding school 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 experiences was like that of an infant in relation to a mother, let's say; having this mother disappear was, in my view, exactly that position that he must have been in an infant during the first years of his life. Now you see mother and begin to internalize her and now you don't see her, 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 seem, 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 and I thought he needed some kind of frame into which he could place some aspects of my countertransference interpretation.

It became clear from the follow up sessions that George had always known about that position in which I was meant to live a life with him. My previous analysis of his anxiety and his defenses against anxiety, although correct, had never reached the core of the issue, and later he told me that he rather despised that I would ever speak up for myself. When I did, instead of burdening him with a sense of guilt, quite the opposite happened, as the fact that up till then I had not personally resisted his created environment had left him feeling doomed and monstrous.

V

Jane is the sort of patient that clinicians often term a "malignant hysteric." Over the years this East European woman in her late
thirties had managed to perfect a technique of exploiting all of her nascent affects into strategic devices to coerce the object 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 and she would hyperbolize her pain into pseudo dementia compelling the boyfriend into a kind of depersonalized solicitousness. 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 in a short while berate herself with incredible emotional violence in the session, knowing, from her point of view, that she now had a true affect around which to cohere a moment's personality.

I have written about some features of countertransference with Jane (Bollas, 1981), 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 toward, a phenomenon not the least enhanced by the fact that she is strikingly beautiful and an accomplished actress. 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 her and consider her), so she needed to affect the object in different ways. As time went on, however, I was also aware that my pleasure in the sight of her was a defense against her emotional life which I found quite paralyzing. 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, a phenomenon which I realized is somewhat similar to classical hysterical conversion symptoms, only in the contemporary hysteric it is not her body and self that is innervated but the analyst who is innervated in his countertransference. I became aware, that is, of the numbing of my self states while I was in her presence, a phenomenon that I think is quite common in those clinicians who work with very hysterical patients.

Often her actions in any one session were so unpredictable, her moods so varying, that I never had a sense of where she was, although I knew that she intended this to be so. Once she leapt out of her chair and flung herself toward 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 its 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 reminded me a bit of Gracie Allen's personifications of the unbelievably scatty woman, and like Gracie Allen she would suddenly scream something out and actually manage to get people in the surrounding area concerned about what was happening.

Such was her expertise at distressing people that her previous analyst 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 he was not at all sure that he could provide psychiatric cover as he found her extremely upsetting, and was concerned because he had begun to shake in the interview with her, something which she had noticed and of course had laughingly used to denigrate him.

For quite some time I was interpretively firm. I would concentrate on how she felt she could only communicate with someone if she would coerce them and whenever she was attempting this with me (almost all the time) I would calmly inform her what I thought she was doing. Although this did settle her a bit and eventually become 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 the varied classical stances. When I was with her I would often privately regret having her as a patient and would think of what passably legitimate way I could get rid of her; maybe she would move away, perhaps she would become truly 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. More than a few times I thought I would have to tell her that unfortunately I was unable to continue with her and I would tell her about how private practise has its limits and so forth, but I knew that these feelings were the emergent creation 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 then, I can now confess—she felt I was helping her.
Then one session she came and plonked herself in the chair, a kind of silly grin playing on her face, and 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 teenie bit warmer. (A gushing effusive laugh follows this). I mean, I wonder if you could just be a teenie bit warmer. Not much warmer. Just an insie bit. Its just that you are so cold." It is impossible, I fear, to convey just how maddening this woman can be as the unreality of her self presentations is truly so unbelievable as almost to defy communication altogether. Nonetheless, although I thought to myself at first, when she embarked on her scripted searching comments, oh my god, here we go again, I felt quite differently 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 it was true 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 establish my experience of her and to make this observation 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, its my view that if you could convince yourself to stop being so God damned 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? Hum. Could you just tell me something about that, about how I do it?" I said "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 from, "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 at most. 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 effectively analyze her false self. I was able to directly identify her unbelievable self, often announced by saccarine confessions, more madening when conveying 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 an effective and confronting container for such moments as it gave her notice of an interpretation such as "you haven't thrown enough sugar on your remarks" which, crass as it may sound, actually were given by me with a sense of relief and enabled me to feel warmly towards her, as 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 neurotic 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 the sense of personal reality in one's work with such patients before a more classical means of working can be initiated. The occasional, more direct use of one's countertransference as the object of the patient, may be what is needed to initiate analysis proper, and, although it could never become a substitute for contemporary "classical" analysis it is my view that without such interventions, a patient may be analyzed but never reached, and inevitably, never helped by the analytical process.

Discussion

As it is my view that many patient's convey their internal world through the establishment of an environment within the clinical
situation, and that they necessarily manipulate the analyst through object usage into assuming different functions and roles, then it is very often the case that the location of freely associated ideas—of those thoughts that spontaneously register the content of psychic life—is now in the psychoanalyst. This is so because the full articulation of preverbal transference evolves in the analyst's countertransference, and, in that interaction, the analyst must function as a transformational object where he identifies his affects, tries to cognize them, and gives them verbal representation to make interpretative use of his countertransference.

Although psychoanalysts have increasingly valued the countertransference as a private source of information, I do believe that it is possible for the clinician to report selected subjective states to his patient for mutual observation and analysis. By disclosing certain 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 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 over all interests of the psychoanalysis.

It should be needless to say that 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. But such is the near phobic dread of this area of technique within psychoanalysis that I shall nonetheless state that the analyst must use such interventions sparingly and only to facilitate the analytic process. Furthermore, it is essential that the clinician analyze those responses in the analysand that 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 find himself saying "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, and 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"; or, "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." Each analyst, that is, must simply be very tuned in to the patient's unconscious response to his intervention, as Langs (1979) has stressed in his writings, and so long as this unconscious reaction or comment is fully analyzed, then 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 interventions when the analyst says "I feel" or "I have a hunch" 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.

I am aware that some clinicians who value the countertransference believe that the analyst should make private use of this information and proceed to make interpretations in the transference. 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 side steps the truth a bit. To be sure, analysts do learn from their countertransference experience, and equally, it is often true that up to a point patients do have a sense that they are communicating, by forcing the analyst into a certain position without a session, but the patient and analyst may not know for a very long time indeed what the eventual meaning is of a cumulative establishment of the transference, and, by making certain subjective states known to the analysand, the analyst enables the transference-countertransference discourse to be analyzed as it develops.
If I had said to Helen, for example, "I think through your self-interruptions you intend for me to have some knowledge of what it means or feels like to be lost" I believe this would not have been entirely true, as 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. By telling her in a very limited manner what I felt, I make my state of mind the object of the session, and I imply that the genesis of this aim to know emerges from the object's need to inform the subject, that the unconscious use of the other is representing distress. 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, and that 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 somewhere for me to know this, but my intent is to provide a potential space in which the analysand can give consideration to the unconscious motives that organize her character. In my view, this intervention would have been a false one—and was only meaningful to Helen—because the transference interpretation followed my countertransference disclosure.

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

When an analysand uses language on the cheap, it is not only that such a patient may use language to discharge themself of pain or excitation, but it is also the case that the analyst's words are not valued as symbolic representations of meaning. In the more classical situation the analyst used that silence that is the hallmark of most analyses as a sound background from which speech expressed meaning, and patient and analyst listened to the free associations. Susan Sontag (1966) puts the uses of silence quite brilliantly:
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. (p. 20).

But 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, alternately, speak not at all, except for lifeless mumblings, as they exist in a kind of listless inertness. The analytical task is quite a difficult and challenging one with such patients as the analyst must find some way to give weight to language, to give it body. In many many ways, 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 (1974) concept of interpretation following the "vectors of being and experiencing"; it is related to Bion's (1977) idea of the evolution from Beta to Alpha functioning and thinking; it is relevant to Langs (1979) typology of transference communications.

The clinician, that is, must function openly as a transformational object. He must indicate that he perceives something, even if the nature of such 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. In doing this, the analyst 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 (willingness to live with the infant utterance), and transformation into some form of representation and possibly some resolution (gratification, ending of distress).

- 33 -
In order to reach many of our contemporary patients I think it is necessary for the analyst to use himself more directly as an area of shared knowing through his experiencing. From his experiencing he can establish not only the value of feeling states and subjective states, but he can find a way to use this form of countertransference experiencing for eventual knowing. If he can not find a way to do this, it is my view that he may well preserve a quiet belief in the patient that psychoanalysis turns away from very significant areas of being, knowing, and truth.

REFERENCES
Bion, W. 1977 The Seven Servents New York: Jason Aronson, Inc.
Bollas, C. 1979 The transformational object Int. J. Psychoanal. 60:97-107
Bollas, C. 1981 Comment l'hystérie prend possession de l'analyste Nouvelle Revue De Psychoanalyse XXIV 279-286
Freud, S. 1912 Recommendations to physicians practising psychoanalysis Standard Edition 12 111-120
Heimann, P. 1960 Countertransference British Journal of Medical Psychology 33 9-15
Lewin, B. 1946 Sleep, the mouth, and the dream screen The Psychoanal. Q. 15:419-434
Sontag, S. 1966 The aesthetics of silence In Styles of Radical Will New York: Dell Publishing Co..
Tauber, E. 1954 Exploring the therapeutic use of countertransference data Psychiatry 17 331-336