Analysing Forms Of Aliveness And Deadness Of The Transference-Countertransference

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The sense of aliveness and deadness of the transference-countertransference represents a critical dimension of the analytic experience and may be the single most important measure of the moment-to-moment status of the analytic process. In this paper the author presents four clinical discussions that illustrate the importance of analysing the experience of aliveness and deadness in (of) the transference-countertransference. In each vignette particular emphasis is placed on the use of transference interpretation derived from experience in the countertransference to address the defensive and expressive role of the dynamic movement of aliveness and deadness at a given juncture in an analysis. The role played by the experience of aliveness and deadness in the structure of the patient’s internal object world and quality of object relatedness is examined.

We’ll hunt for a third tiger now, but like
The others this one too will be a form
Of what I dream, a structure of words, and not
The flesh and bone tiger that beyond all myths
Paces the earth. I know these things quite well,
Yet nonetheless some force keeps driving me
In this vague, unreasonable, and ancient quest,
And I go on pursuing through the hours
Another tiger, the beast not found in verse.

The Other Tiger, J. L. Borges, 1960.

I have become increasingly aware over the past several years that the sense of aliveness and deadness of the transference-countertransference is, for me, perhaps the single most important measure of the moment-to-moment status of the analytic process. In the course of four clinical discussions, I shall explore the idea that an essential element of analytic technique involves the analyst’s making use of his experience in the countertransference to address specific expressive and defensive roles of the sense of aliveness and deadness of the analysis as well as the particular function of these qualities of experience in the landscape of the patient’s internal object world and object relationships. From this perspective, the problems of central concern to analyst and analysand tend to focus increasingly on such questions as: when was the last time the analysis felt alive to both participants; is there a disguised vitality that cannot be acknowledged by analyst and/or analysand for fear of the consequences of its recognition; what sorts of substitute formations might be masking the lifelessness of the analysis, e.g. manic excitement, perverse pleasure, hysterical acting in and acting out, as-if constructions, parasitic dependence on the inner life of the analyst, and so on?

The ideas that I shall present are based in large part on Winnicott’s (1971) conception of the ‘place where we live’ (a third area of experiencing between reality and fantasy [1951]) and the problems involved in generating such a ‘place’ (intersubjective state of mind) in the analysis. I am also drawing heavily upon Bion’s (1959) notion that the analyst/mother keeps alive, and in a sense brings to life, the analysand’s/infant’s projected aspects of self through the successful containment of projective identifications. Symington’s (1983) and Coltart’s (1986) discussions of the analyst’s freedom to think represent important applications to analytic technique of the work of Bion and Winnicott. Green (1983) has made a pivotal
contribution to the analytic understanding of the experience of deadness as an early internalisation of the unconscious state of the depressed mother.

A great deal has been written in recent years about the importance of the analyst’s 'realness', i.e. his capacity for spontaneity and freedom to respond to the analysand from his own experience in the analytic situation in a way that is not strangled by stilted caricatures of analytic neutrality (see for example, Bollas, 1987; Casement, 1985; Meares, 1993; Mitchell, 1993; Stewart, 1977). As will be clinically illustrated, my own technique rarely includes discussing the countertransference with the patient directly. Instead, the countertransference1 is implicitly presented in the way I conduct myself as an analyst, for example, in the management of the analytic frame, the tone, wording and content of interpretations and other interventions, in the premium that is placed on symbolisation as opposed to tension-dissipating action, and so on.

I shall attempt to develop several ideas having to do with technical problems involved in recognising, symbolising and interpreting the sense of aliveness and deadness of the analytic experience. I believe that every form of psychopathology represents a specific type of limitation of the individual's capacity to be fully alive as a human being. The goal of analysis from this point of view is larger than that of the resolution of unconscious intrapsychic conflict, the diminution of symptomatology, the enhancement of reflective subjectivity and self-understanding, and the increase of sense of personal agency. Although one's sense of being alive is intimately intertwined with each of the above-mentioned capacities, I believe that the experience of aliveness is a quality that is superordinate to these capacities and must be considered as an aspect of the analytic experience in its own terms.

The focus of this paper is clinical. My effort will not be to define psychological aliveness and deadness or even to attempt to describe how we determine whether, or to what extent, a given experience has the quality of aliveness or of deadness. It is not that these questions are unimportant. Rather, the best way I have of addressing these questions is to discuss clinical situations that I believe centrally involve these qualities of experience and to hope that the descriptions themselves convey something of a sense of the ways in which aliveness and deadness are consciously and unconsciously experienced by analyst and analysand. In the four clinical discussions of forms of psychological aliveness and deadness that follow, particular attention is paid to the ways in which countertransference experience is utilised in the process of creating analytic meaning, i.e. in the process of recognising, symbolising, understanding and interpreting the leading transference-countertransference anxiety.

In the first clinical discussion, I will present fragments of an analysis in which the patient's sense of deadness could not initially be symbolised and instead was enacted (entombed) in the lifelessness of the analytic experience itself. The focus of this discussion will be on the use of the countertransference to generate verbal symbols that are eventually offered to the patient in the form of interpretations.

Ms N, a highly successful civic leader, began analysis because she felt intense, but diffuse anxiety and believed that something was seriously wrong in her life, but did not know what it was. In the initial meetings the patient did not seem to consciously experience feelings of emptiness, futility or stagnation. She said that she felt at a loss for words, which was

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1 I use the term countertransference to refer to the analyst's experience of and contribution to the transference-countertransference. The latter term refers to an unconscious intersubjective construction generated by the analytic pair. I do not view transference and countertransference as separable entities that arise in response to one another; rather, I understand these terms to refer to aspects of a single intersubjective totality experienced separately (and individually) by analyst and analysand.

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something that was highly uncharacteristic of her.

The first year and a half of analysis in many ways had the appearance of a satisfactory beginning. The patient was able to see more clearly the specific ways in which she kept people (including me) at a great psychological distance. There was also some decrease in anxiety, which was reflected in the patient's increasingly less rigid body posture on the couch. (For almost a year, Ms N had lain completely still on the couch with her hands folded on her stomach. At the end of the meeting, the patient would bolt from the couch and briskly leave the room without looking at me.) The language the patient used was initially equally stiff and often sounded text-bookish. Her speech pattern became somewhat more natural in the course of the initial year of work. However, the patient throughout this period had profound doubts about whether the analysis was of
any real value’ to her. Ms N felt that she was developing no greater understanding of either the source of her anxiety or of her sense that things were not right in her life.

In the course of the first half of the second year of work, I gradually developed an awareness of the way in which the patient would fill the hours with apparently introspective talk that did not seem to develop into elements from which further understanding or interpretation could be generated. A pattern developed in the hours in which Ms N would describe events in her life in minute detail. It was not at all clear what the point of the lengthy descriptions was. At times, I would say to the patient that I thought that she must be very anxious that I would learn too much about her if she helped me to understand the significance of what she had just said.

I found that I experienced increasingly less curiosity about the patient, which absence had quite a disturbing effect on me. It felt equivalent to losing the use of my mind. I experienced a form of claustrophobia during the hours and on occasion defended against this anxiety by obsessionally counting the minutes until the hour would be over. At other times, I fantasised ending the hour prematurely by telling the patient that I was ill and needed to end the session. I would sometimes ‘pass the time’ by counting the beats per minute of my radial pulse. I was initially unaware that there was anything odd about my taking my pulse despite the fact that this is a practice that has never occurred with any other patient. As the thoughts, feelings, and sensations associated with this activity were occurring, they did not feel like ‘analytic data’. Instead, I experienced them as an almost invisible, private background experience.

During the period of weeks that followed, I gradually became more able to treat the taking of my pulse, as well as the associated feelings and sensations, as ‘analytic objects’ (Bion, 1962; Green, 1975; Ogden, 1994a, d), i.e. as a reflection of an unconscious construction being generated by the patient and myself, or more accurately being generated by the ‘intersubjective analytic third’. I have discussed my conception of the ‘intersubjective analytic third’ (or ‘the analytic third’) in a recent series of publications (Ogden, 1992a, b, 1994a, b, c, d). To summarise briefly the ideas presented in those publications, the intersubjective analytic third is understood as a third subject created by the unconscious interplay of analyst and analysand; at the same time, the analyst and analysand qua analyst and analysand are generated in the act of creating the analytic third. (There is no analyst, no analysand, no analysis, aside from the process through which the analytic third is generated.)

The new subjectivity (the analytic third) stands in dialectical tension with the individual subjectivities of analyst and analysand. The intersubjective analytic third is not conceived of as a static entity; rather, it is understood as an evolving experience that is continually in a state of flux as the intersubjectivity of the analytic process is transformed by the understandings generated by the analytic pair.

The analytic third is experienced through the individual personality systems of analyst and analysand and is therefore not an identical experience for each. The creation of the analytic third reflects the asymmetry of the analytic situation in that it is created in the context of the analytic setting, which is structured by the relationship of roles of analyst and analysand. The unconscious experience of the analysand

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is privileged in the analytic relationship: it is the experience of the analysand (past and present) that is taken by the analyst and analysand as the principal (although not exclusive) subject of the analytic dialogue.

I began to be able to link the experience of holding my own wrist (in the act of taking my pulse) with what I now suspected to be a need literally to feel human warmth in an effort to reassure myself that I was alive and healthy. This realisation brought with it a profound shift in my understanding of a great many aspects of my experience with Ms N. I felt moved by the patient’s tenacity in telling me seemingly pointless stories for more than 18 months. It occurred to me that these stories had been offered with the unconscious hope that I might find (or create) a point to the stories thereby creating a point (a feeling of coherence, direction, value and authenticity) for the patient’s life. I had previously been conscious of my own fantasy of feigning illness in order to escape the stagnant deadness of the sessions, but I had not understood that this ‘excuse’ reflected an unconscious fantasy that I was being made ill by prolonged exposure to the lifelessness of the analysis. It was through this and similar lines of thought and feeling (associated with my own experience in the analytic third) that I began to develop a sense of the meaning of the patient’s diffuse anxiety and her sense that she was caught in something awful that she could not identify.

I said to Ms N that I thought I understood better now some of the reasons for her telling me in great detail about events in her life in a way that made it confusing to both of us why she was telling the story. I said that I felt that she had given up on being able to create a life for herself. Instead, she was giving me the forms with which she had filled her time in the hope that I could create a life for her from these pieces. The patient

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responded by describing the way in which her life at work and at home consisted almost entirely of organising other people's activities while never actually making anything herself. It now seemed to her that she used other people's lives and the things that they made (the lives of her employees, of her husband, her au pair, and her two children) as a substitute for her own ability to create something that felt like a life of her own.

Later in the session, she said that she had for a long time imagined that a paperweight on a table next to her chair had been a gift from a patient. She said that she had never told me that she had even noticed the object, but that she had for a long time wished that she had given it to me. It was not until that moment that she realised that she had not imagined giving me a gift of her own, and instead had wished that she had given me that gift. She could not envision herself as a person who could select, and in that sense create, a gift for me, so she imagined being someone else, the person who had given me the gift. I thought, but did not interpret at this juncture, that underlying this thought was the fantasy that it would never be possible for her to create a life of her own so the only alternative available to her was that of stealing the life of another person. It seemed important that I should not usurp the patient's opportunity to create life in the analysis (create interpretations) that she was now just beginning to be able to do.

Several months later, Ms N presented a dream in which she was in a kitchen that was not her own kitchen. It was as if she had been 'poured into the cabinet' and had become a rectangular cube the shape of the inside of the wooden box. The dream was presented in conjunction with the patient's telling me about a friend who lived with continual psychological pain in connection with the death of her 5-year-old daughter. The friend's child had been killed before the patient began analysis, in an accident that had resulted from the negligence of a baby-sitter.

After telling me the dream, Ms N fell silent. This silence stood in marked contrast to the way in which she had in the past obscured feeling with excessive verbiage. After a few minutes, I said to Ms N that I thought that she was describing to me her sense that she lacked a shape of her own. I went on to say that her friend's pain, however terrible, was a human feeling that I thought the patient feared she was incapable of experiencing. I told her that although she had never said so directly, I felt that she was afraid that she might never be able to feel anything, even the pain that others might feel about the death of their child.

In a voice so faint that I could barely hear her, Ms N said that this had for a long time been a fear of hers about which she felt enormous shame. She had stayed awake many nights worrying that she would be unable to grieve if one of her own children were to die and that this felt to her to be the most odious failure of which any mother could be guilty. She said that she felt that she had not been able to love and be with her children in the way that she wished she could have been. In fact, she now knew that she had neglected them quite badly and that they had suffered greatly for it. The patient then fell silent for the remaining few minutes of the hour.

To summarise, I view the portion of the analysis just discussed as representing the beginnings of a process in which the patient's experience of deadness (both in her imagined inability to grieve and in her identification with her friend's dead child) was being transformed from an unthinkable thing-in-itself (a fact experienced by both the patient and myself as a non-verbally symbolised sense of deadness of the analysis) into a living, verbally symbolised experience of the patient's (and my own) deadness in the analysis. An intersubjective analytic space had begun to be generated in which the deadness could be felt, viewed, experienced and spoken about by the two of us. Deadness had become a feeling as opposed to a fact.

II

In this second clinical discussion, I shall describe an analytic encounter which illustrates technical challenges arising in conjunction with a patient's unconscious insistence that the analyst serve as the repository for his psychic life and hope.

Mr D, in the initial interview, informed me that he had been in analysis six times and each time 'had been terminated' by the analyst. The most recent unilateral termination had occurred three months prior to Mr D's first meeting with me.

The patient carried himself and spoke in a way that conveyed a sense of arrogance, aloofness and self-importance; at the same time, this deportment had a brittleness to it that made it readily apparent that the patient's superior tone of voice and demeanour thinly disguised feelings of fear, worthlessness and desperation.

Mr D told me that if he were to continue past our initial meeting, I must understand that he would never be the one who spoke first in any session. He explained that if I were to attempt to 'wait him out', the session would be spent in complete silence. He had wasted his time and money in that way too many times in the past.

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and hoped that I would not repeat that approach with him. He added that it would also be a waste of time for me to ask him about the ‘fears and anxieties’ underlying his inability to begin the session: ‘After all, my answering questions of that sort would be tantamount to my beginning the hour—you know that as well as I do’.

Mr D’s presentation of himself intrigued me and stirred feelings of competitiveness in me. He had thrown down the gauntlet and I would prove myself to be more adept and agile than the previous six analysts. In the initial interview I was also aware that I was unconsciously being invited to take the role of a suitor and that there was a fantasised homosexual sadomasochistic scene that was already beginning to take shape in the transference-countertransference. At the same time, I recognised that the fantasy of entering into a competitive game protected me from fully feeling the deadly seriousness of the intense contempt and hatred that I was encountering. In addition, the narcissistic/competitive fantasy protected me from feelings of being trapped in the web that Mr D was already beginning to spin with his imperiously controlling instructions regarding the way in which the analysis was to be conducted. I imagined that long years of isolation awaited both of us if we were to undertake analysis together.

I said to Mr D that I thought he imagined that analysis with me would involve one or both of us brutalising the other—until the one being brutalised could no longer bear it. I also said that I had no interest in brutalising him, being brutalised by him or participating in his brutalisation of himself. This comment was not meant as a reassurance, but as a statement about my conception of the analytic framework within which I was willing to work. I agreed to be the first to speak in each hour, but said that I would do so only when I thought I had something to say. I added that it might sometimes take me a good deal of time to be able to put my experience into words for myself and for him at the beginning of the session, but my silence would not be intended as an attempt to ‘wait him out’.

Mr D sat quietly and seemed to relax a bit as I spoke. I was somewhat encouraged by the fact that I felt that I had been able to say something to him that did not involve a sadistic attack on Mr D nor a compromise of either of us. Neither did it seem to me to involve a form of manic excitement and denial related to the fantasy of a competitive game.

At the outset of each of the meetings with Mr D, I attempted to find words to convey what it felt like being with him in that particular moment. I (silently) hypothesised that both the fantasies and feelings about brutalisation and the fantasies reflecting manic excitement (competition) in the transference-countertransference represented forms of defence against the experience of inner deadness, which deadness was symbolised by Mr D’s feeling that he had nothing in him with which to begin the hours (to begin his story). I would have to be the one to bring life to the analysis (to create history) each time we met. Almost always as I began the hour, I had the conscious fantasy that I was giving the patient and the analysis mouth-to-mouth resuscitation. I chose not to tell Mr D about this fantasy directly in order not to demean him or prematurely to address the homosexual aspects of the transference-countertransference.

At times, what I said to Mr D to begin the hour felt rote and hackneyed and I laboured to get beyond what felt like pre-fabricated analytic cliché in order not to dump further lifelessness into him and into the analysis. In one of these meetings very early on in the analysis I told Mr D that I had found myself imagining attempting to lure him into trusting me. I said that I knew that this would not only be futile, but would also be destructive since anything ‘won’ by me in this way would be experienced by both of us as a form of theft that would alienate us from one another even further than we already were. After several minutes of silence, Mr D described his continual vigilance in combating theft: his use of burglar alarms at his home, anti-theft devices in his car, a safe at his office, and so on. This was spoken in a way that gave no acknowledgment that it represented a response to what I had just said. Despite the patient’s offering information of this sort, the feeling in the hour was that of an extremely tense stand-off which threatened to break apart at any moment. It felt as if there were nothing human holding the fabric of the analysis together.

In a session that occurred in the sixth month of the analysis, I thought for a moment that I saw tears brimming in Mr D’s eyes, but when I looked more closely I could not tell if my perception had been accurate. (Mr D was at that point refusing to use the couch and so we were meeting face to face.) I told Mr D what had just occurred and said that whether or not there had been tears in his eyes, I felt that what had happened reflected the sadness of the situation that he and I were in. (I remembered Mr D’s telling me some months earlier that he had been grateful to his previous analyst for her honesty in telling him that she could not be of help to him instead of mindlessly persisting in an analysis that she felt could not progress. That thought reminded me of a ‘living will’ that had recently been sent to me by a member of my family in which doctors were in effect instructed not to create an empty illusion of life after genuine life had already been lost.)
Mr D sat quietly for a minute and said that he had not been moved by my 'little speech'. He then returned to his silence. After about five minutes, I said I thought that what had just happened between us must reflect something basic to his experience. I had felt sadness, part of which was no doubt my own, something attributable to my own sense of extreme loneliness in being with him. I added that nonetheless I felt that in part I was feeling something for him, in his stead. I said that I had in the past tried to talk with him about it, but that his replies had always made me feel as if I were either crazy or stupid or both. I said that if I were not in a position to feel some confidence in my ability to differentiate between what feels real and what does not, I would find it a great strain to have my perceptions drawn into question in such a fundamental way. I told him that it would surprise me greatly if at important points in his life, he had not felt this type of strain in relation to his own ability to differentiate which parts of his experience and perceptions were real and which were not. It seemed from my experience in being with him that he must have felt powerfully assaulted in his efforts to hold on to a conviction about the truth of what he thought, saw, felt, heard and so on.

The patient seemed to ignore almost all of what I had just said and instead commented that I had used the word 'brutalised' at our first meeting. That word was the most accurate word, and 'maybe the only accurate word', that I had used in all of these analyses. He said that he had never been beaten or abused as a child, but he had felt that he had been brutalised in subtle and in not so subtle ways that he cannot describe because he is not even sure what occurred, if in fact anything out of the ordinary did occur. Mr D said that he would not try to tell me about his childhood because it was all very normal—'I've gone over it a hundred times with my previous analysts and there isn't anything that would earn me a place on the Donahue Show'.

This exchange was the closest Mr D and I had come to talking to one another. Over the next several weeks, he became increasingly antagonistic and disparaging of me and the analysis. I interpreted the fact that his attacks on me and our efforts to talk to one another had increased dramatically after the meeting that I have just described. At one point, the patient expressed great contempt for my use of the word 'work' to describe what was occurring in these 'very expensive hours'. I said to Mr D that earlier he had commented on my use of another word, the word 'brutalised'. I told him that I thought that his having acknowledged feeling understood by me, if only in my use of that single word, had led him to feel that things between the two of us had become wildly and dangerously out of control. I said that I thought that what currently appeared on the surface to be his brutalising me felt to me more like an effort to protect me by getting me to throw him out. I added that I suspected that if I did not soon terminate our meetings he would end the analysis as the only way he felt he had at his disposal to protect me from what he feared to be his endlessly escalating brutalisation of me. Mr D did not end the analysis, but for a period of almost six months he turned his chair at the beginning of the meeting so that his back was to me. I suspect that he did not want me to be able to see his eyes. In that phase of work, he spoke even less than in the initial months of analysis.

In the portion of the analysis discussed above, Mr D had in fantasy put into me the fragile remainder of his sense of life and hope. I was to speak for him and feel for him (by beginning each meeting and by being the container of his projective identifications involving his profound loneliness and sadness) while he attacked me for being so naive as to imagine that I could safeguard his life and my own in the face of his immense brutality. Extreme splitting of the brutalised and brutalising aspects of the patient had been a necessary condition for any form of relatedness to me to be sustained. In the course of the analysis, the patient began to experience for himself the rudiments of sadness and compassion for the aspects of himself which he had projected into me and had experienced through me.

III

In ongoing consultation with clinicians who come to me to discuss analyses that they are conducting, I ask that the analyst attempt to talk with me not only about what the analyst and analysand say to one another, but also about the analyst's moment-to-moment thoughts, feelings and sensations. The analyst is asked to include this aspect of his work in the process notes that he records during the analytic hours and discusses with me in our consultation meetings. In addition, I suggest that the analyst should write process notes for all meetings including those that the patient fails to attend.
I operate under the assumption that the patient's physical absence creates a specific form of psychological effect in the analyst and in the analysis and that the analytic process continues despite the analysand's physical absence. In this way, the specific meanings of the patient's presence in his absence are transformed into analytic objects to be fully experienced, lived with, symbolised, understood and made part of the analytic discourse.

In using process notes in this way, the analyst attempts to symbolise and speak to himself about his experience with the patient, no matter how seemingly unrelated to the analysand the analyst's fantasies, physical sensations, ruminations, daydreams, and so on might appear to be (Ogden, 1992a, b, 1994a, b, c, d). I do not 'insist' that a supervisee discuss with me this aspect of the analytic experience since some analysts are initially temperamentally incapable of attending to this level of their experience. Moreover, the analyst consulting with me are not always sufficiently at ease with themselves or with me to entrust this aspect of their work to me. However, I have found that as the supervisory relationship unfolds, supervisees are usually able to develop these capabilities and make use of this aspect of the analytic experience in their therapeutic work and in consultation. I have also found that it is rare for a therapist to be able to engage in this form of supervisory experience without having previously taken part in a successful personal analysis. In the absence of such an experience in analysis (which is not to invoke the illusion of the 'completed analysis'), it is unusual for a therapist to have developed the capacity to make analytic use of his mundane, quotidian unobtrusive thoughts, feelings and sensations that occupy him during the analytic hours.

As with most aspects of analytic technique, attention to and use of the analyst's private discourse that is seemingly unrelated to the patient runs counter to the character defences that we have developed in the course of our lives. To attempt to loosen our dependence on these character defences often feels like 'tearing off a layer of skin', leaving us with a diminished stimulus barrier with which to protect the boundary between inner and outer, between receptivity and overstimulation, between sanity and insanity.

The analytic work that I shall now describe occurred in the context of the supervision of an analyst who had been consulting with me on a weekly basis for about a year. The analysis had begun in a way that was quite disappointing to the analyst. The analysand, Dr C, was a resident in family practice medicine who had read about psychoanalysis in college, medical school and residency. He had a strong sense of the 'rules of analysis' and complied with them, although from the beginning he complained about the rigidity of the 'game', for example the analysand's having to pay for missed meetings, the 'requirement' that the analysand take his vacations when the analyst does, the demand for compliance with the 'fundamental rule', etc. (With the exception of the fee arrangement, the analyst had said nothing about these 'rules'.)

Dr C's reasons for being in analysis were vague: he felt he should 'learn about himself' as part of his training as a family practice physician. The idea that he was asking for help with the psychological pain that he was experiencing would have represented an imagined act of submission that the patient could not have tolerated at the beginning of the analysis. The analysand was on time for each session and complacently 'free associated', presenting a blend of dreams, childhood memories, sexual fantasies and current work-related, marital and child-rearing difficulties and stresses. There were confessions of secret acts about which the patient felt shame, for example, the use of pornographic magazines during masturbation and two incidents of cheating on medical school laboratory reports.

However, from the earliest days and weeks of analysis, the analyst, Dr F, experienced the patient as boring to a degree to which he was unaccustomed. It felt as if the patient were attempting to imitate what he had imagined went on in a 'good analysis'.

It required considerable forbearance for Dr F to refrain from entering into the analysis with interpretations of the content that was being presented, for example, interpretation of dream material that 'seemed to beg for transference interpretations'. In consultation, Dr F discussed the possible interpretations that he might have made, but had chosen to defer. It seemed to me that these interpretations would have been imitations of 'deep' transference interpretations and would have been offered in an effort on the part of Dr F to create his own fantasy of a 'good analysis'. As time went on, the analyst felt greatly tempted to chastise the analysand or even comment contemptuously on the emptiness of the patient's verbiage. At each stage, an important perspective that was elaborated in the consultation included the idea that it was of critical importance for Dr F not to enter into an empty (inert) discourse with the patient and at the same time it was crucial that the analyst maintain his capacity to entertain any thought, feeling, or sensation that arose within him (see Bion, 1978; Symington, 1983). No possible interpretation or response to
the patient was to be reflexively dismissed or stifled. It required enormous psychological effort on the part of Dr F to resist becoming mechanical, detached or imitative of an idealised version of his own analyst or of me.

Dr F developed his own style of taking process notes in which he was able to capture something of the totality of the experience of the hour including the details of his own experience. I think of this as the effort of the analyst to focus upon the countertransference aspects of the transference-countertransference as ‘total situation’ (Joseph, 1985; Klein, 1952; Ogden, 1991). In other words, it is the transference-countertransference, not simply the transference, that constitutes the matrix in which psychological meanings are generated in the analytic situation.

As Dr F would present the hours to me in our weekly consultation sessions, neither of us felt pressured to draw one-to-one correspondences between Dr F’s thoughts and feelings and those of the patient. At times, we each offered tentative understandings of the relationship between Dr F’s experience and what was happening in the analytic hour. Usually, Dr F’s reveries were simply noted and were allowed to reverberate within him and me as we listened to the subsequent material. We sometimes referred back in our discussions to reveries that Dr F had presented in consultation meetings weeks or months earlier.

Dr F’s thoughts in the initial months of analysis often included wishful images of his upcoming vacations or of memories of recent browsing in interesting shops and bookstores during his afternoon breaks. These were understood not simply as generic escapist fantasies, but in each instance were felt to reflect a specific response to what was occurring in the analysis at that particular moment. At one point, several of Dr F’s vacation daydreams were of an unrealistically idealised sort and seemed to reflect the make-believe nature of the analysis. The patient did not want an actual analysis; he defensively desired a perfect one. In other words, the analysand unconsciously wished for an omnipotently created analysis that did not involve actual encounters between himself and another person with all the anxieties associated with the human lapses, misunderstandings and so on that would have entailed.

Dr F attempted to keep alive in himself his capacity to be curious, to question, to comment spontaneously on what was occurring in the analytic interaction despite the ‘canned’ responses that he would often receive from the patient. ‘Analytic etiquette’ was not treated as sacred by Dr F, much to the surprise and disapproval of the patient. For instance, the patient at one point indicated that he wanted advice from Dr F, but immediately added that he knew that Dr F could not give him advice. Dr F responded by asking the patient why he could not give the patient advice. In the end, no advice was given, and instead there was a discussion of the patient’s use of fantasised rules (his own omnipotent creations and projections) for the purpose of preventing himself from experiencing and thinking about the personal, idiosyncratic, unpredictable nature of the experience that was occurring between himself and Dr F.

When Dr F found himself feeling curious about an aspect of the material that the patient was discussing, he asked the patient for further details even when the questions seemed tangential. For example, at one point, Dr F asked the patient for the name of a restaurant that the patient had parenthetically mentioned having enjoyed the previous evening. The analyst was well aware that the omission of the detail (the name of the restaurant) very probably represented a way of tantalising and excluding the analyst (a projection of the patient’s curiosity and feeling of exclusion from the life of the analyst). However, at the time, Dr F decided to ask (perhaps more accurately, found himself asking) for the detail about which he felt curious while deferring exploration of the tantalising effect of the omission of this particular detail. (Coltart [1986] has made a similar recommendation with regard to allowing oneself to laugh at a patient’s jokes before analysing the conscious and unconscious motivations of the patient’s wish to get the analyst to laugh.)

It should be emphasised that while Dr F attempted to insure space in the analysis for spontaneity and ‘freedom of thought’, he by no means treated the analytic frame in a cavalier way—hours were begun and ended in a timely way; casual conversation did not occur between the waiting room and the consulting room; suggestion, reassurance, exhortation, and the like played no larger a part in this analysis than in others conducted by this careful and thoughtful analyst.

For most of the first year of analysis, Dr F felt that the life of the analysis resided almost entirely in his own capacity to maintain his freedom for reverie during the analytic hours and in his discussions with me of these reveries. By the beginning of the first half of the second year of analysis, the patient began to demonstrate changes in his ability to speak with a voice of his own that no longer seemed quite as clichéd, stereotypical and imitative as before. However, the changes seemed fragile and shortlived to Dr F.

In this period of the analysis, Dr F presented a session in consultation in which the patient was silent for the first few minutes of the meeting. Dr F told me that during this period of silence he had been thinking about the
fact that I would be spending my Christmas break in Hawaii. He wondered if I would take Christmas presents along with me on the trip, all wrapped in shiny red and green paper. He imagined how odd it would be to exchange Christmas gifts in Hawaii and pictured my wife giving me a woollen sweater as a Christmas gift. I commented that I thought Dr F was expressing scepticism about some of the ideas that we had been discussing in the course of the supervision, particularly the emphasis I had been placing on the importance of Dr F's capacity for creativity and spontaneity in his work (as opposed to adopting reflexive, imitative, prefabricated approaches).

In the course of discussing Dr F's reverie concerning my vacation, I said to Dr F that I thought that he was depicting me as participating in a self-deceptive charade in which I was treating Christmas as something that could be dug up and moved from one place to another without any change in the experience as one might move a plant from one side of a garden to another. The feeling in the daydream was that Christmas had become entirely a form for me and that I had lost touch with any meaning or feeling beyond the stereotypical form. This reverie depicted Dr F's disappointment, as well as some degree of competitive pleasure, in viewing me as lacking self-understanding with regard to my own mechanicalness.

It seemed to both Dr F and to me that Dr F was saying to both of us, 'Ogden talks a good game about reality, authenticity, genuineness, spontaneity, and so on, but when it comes down to it, maybe he doesn't know what's real and what isn't'. Dr F and I discussed the way in which my placing a premium on spontaneity may have created a dilemma of sorts for Dr F: he may have begun to find himself attempting to 'train himself' to be spontaneous. To make matters worse, he may have unconsciously felt that 'achieving spontaneity' would involve imitating me. Dr F came to see more clearly as a result of the discussion of this Christmas reverie that his patient had been labouring under a similar burden in the analysis for some time. For months, Dr C had said that he felt an internal pressure to be 'on' in analysis, that is, to be interesting to Dr F. Only at this point did Dr C's comment take on an analytic meaning (become an 'analytic object') that could be symbolised, reflected upon and interpreted. Dr F felt that he now better understood that the patient's internal pressure to be 'on' reflected the patient's unconscious

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fantasy that he could only be alive for Dr F to the degree that he could learn to think, feel, speak, and behave in a manner like or the same as Dr F. This placed the patient in an impossible position in which feeling alive and being interesting to Dr F had become synonymous. Paradoxically, the idea of feeling alive had for Dr C become unconsciously equivalent to becoming (an idealised version of) Dr F.

In the course of the succeeding weeks of analysis, Dr F offered to the analysand his understanding of this dilemma that he believed to underlie Dr. C's feeling of pressure to be 'on' in analysis. Both this interpretation and Dr F's self-understanding upon which it rested facilitated the creation of psychological space in the analysis in which both the patient and the analyst were able to continue to develop their capacity to generate thoughts, feelings and sensations without feeling that there was an unstated script or paradigm that either of them was being asked to mouth or imitate.

In the clinical sequence just described, it was essential for the analyst to be able to have his own thoughts independent of mine (which need was symbolised by Dr F's unconscious criticism of me in the Christmas reverie). Only when Dr F became aware of the way in which his own capacity for original thought had been paralysed by his fear of confronting his defensive idealisation of me, could he regain his full capacity for reverie. Dr F's symbolisation of, and understanding of, this defensive process as it was portrayed in the Christmas reverie formed the basis for his interpretation of his patient's futile attempts to overcome his own experience of deadness by (in fantasy) attempting to become a perfect patient, that is, to become a defensively idealised version of his conception of an analytic patient.

IV

The final clinical vignette that I shall present will focus on the problem of 'competing' (Tustin, 1980; see also Ogden, 1989a, b) with a form of deadness that involves a pathologically autistic aspect of personality. In the analysis of adult patients, the autistic component of the personality is often not at all evident in the beginning of analysis (S. Klein, 1980). This was the case in the analysis of Mrs S. In the initial analytic meeting, Mrs S talked about her difficulties in 'getting her life together'. She had not been able to graduate from college as a result of her inability to concentrate. Her marriage was in disarray and she felt on the edge of panic.

It is not possible in the space of the present paper to offer an account of the stages of the evolution of the analytic process over the first eight years of this five session per week analysis. The outcome of these years of
work might be very broadly summarised by saying that despite the fact that there had been important changes in the patient's ability to function in the world (for example, she was able to graduate from college and hold a responsible job), the patient's capacity to enter into relationships with other people remained very limited. Mrs S and her husband slept in separate bedrooms and on occasion engaged in what the patient described as 'mechanical sex'. It had required more than five years of analysis for the patient even to recognise that she 'managed' her three children as if she were 'an employee of a day-care centre' and that she had very little sense of each of them as individuals. Her friendships were shallow and only toward the end of the seventh year of analysis did she begin to feel the absence of loving relationships in her life.

In the analytic relationship, I was again and again stunned (in a way that I have rarely experienced with other patients) by the depth of the patient's inability to show or experience any warmth towards me. It was not that Mrs S did not feel dependent on me. She was greatly distressed by weekend breaks, vacations (her own as well as mine), the end of each session, and would frequently telephone my answering machine in order to hear my voice (without leaving a message of her own). However, Mrs S experienced her dependence not as a personal attachment, but as an addiction that she deeply resented: 'A heroin addict does not love heroin. The fact that she'll kill to get it doesn't mean she loves it or feels any kind of affection for it'. The patient felt powerfully untouchable in her isolation and seemed to

value this feeling of 'being immune to human vulnerabilities' more than anything else in life. This 'untouchable' quality was reflected in her anorectic symptomatology. She subsisted on a diet of fruit, grains and vegetables and organised her life around a rigorous exercise regime that included marathon jogging and the extensive use of a stationary bicycle. The patient exercised vigorously for at least three hours every day. If the exercise routine were in any way disrupted (for example, by illness or by travel), the patient would experience a state of intense anxiety that on two occasions developed into a full-blown panic attack.

Mrs S, at the beginning of the analysis, experienced no appetite for food, sex, ideas, art or anything else. The patient's weight held the greatest importance for her—by maintaining a particular weight (at the very low end of what she could tolerate physiologically without falling physically ill), she experienced a form of power that allowed her in fantasy to control everything that might occur both within her and outside of her.

It would be inaccurate to say that the patient always felt numb or without feelings in the analytic hours. Mrs S frequently experienced intense anger, which she called 'hated', towards me. However, her anger never seemed personal. By this I mean that it never felt as if her anger had anything to do with me. The hatred did not even seem to be the patient's personal creation; rather, it seemed like a blind, reflexive, almost convulsive thrashing about that occurred when her sense of absolute control and ownership of me was compromised. Since I was the person/object who happened to be there, it was I who happened to be the object of her rage. Mrs S's criticism of me always involved her projecting fantasy of my omnipotence: she felt that I could easily give her what she needed if I chose to, but I stubbornly refused to do so.

Other than her single-minded crusade to gain access to my fantasised omnipotent power there seemed to be very little about me that was of interest to the patient. It was difficult for me to accept how little I seemed to mean to this patient outside of the terms of the fantasy I am discussing. For years, I held to the belief that Mrs S secretly loved me (albeit in a primitive way), felt a form of concern for me, knew something about who I am as a person, but stubbornly refused to admit it. This belief was based on the intensity of the patient's feeling of dependence on me in conjunction with the fact that I felt concern for and interest in her. At times, I interpreted what I felt to be the patient's anxiety about acknowledging any feeling of human connection with me for fear of the loss of control over her external and internal world that that would entail. She would respond by saying that what I said might be true, but she was not aware of feeling affection, love, warmth or even concern for me or for anyone else for that matter. The defensive function of such a stance on the patient's part was discussed on many occasions, but did not lead to any discernible affective change. (These interpretations felt increasingly stale to both the patient and to me.)

Perhaps it was the patient's response to the death of my father that was the beginning of my loosening of my hold on the belief that the patient secretly felt some form of love or concern for me. The events transpiring between Mrs S and myself around this event (in the eighth year of analysis) led me to feel that there was a qualitative difference between the human disconnectedness achieved by Mrs S and forms of defence against the dangers of love and hate that I had encountered with other patients. After receiving the unexpected news of my father's death, I telephoned my patients and supervisees to tell them that there had been a death in my family and that I would be cancelling several days' meetings. I told each of them that I would phone them to tell them when I would be resuming work. When I spoke with Mrs S, she received the news quietly, but
immediately asked me if I knew approximately when I would be returning to work. I said that I did not know, but would let her know when I did.

At our first meeting after my return, Mrs S said that she was ‘sorry that someone in my family had died’. There was unmistakable anger in her voice as she underscored the vagueness of the word ‘someone’. She fell silent for a few minutes and then said that it made her feel furious not to know who it was that had died and said that she felt that I had been sadistic in not giving her that information when I phoned her. She added that she was certain that I had told all my other patients who it was in my family that had died. During this interchange, I felt deeply disturbed by a recognition against which I had struggled for most of a decade: it seemed to me that Mrs S was unable to feel anything for me as a human being beyond her need to protect herself by means of her efforts magically to enter me and control me from within.

At this point in the meeting, I began to recall the details of the feelings that I had felt during the telephone call that I had made to Mrs S soon after I learned of my father’s death. I remembered with great vividness the feeling of attempting to control my voice as I spoke to her in an effort to hold back tears. I wondered whether it was possible that she heard nothing of that. How could she not have experienced that moment (as I had) as one in which there had been a close connection between the two of us? Instead, she apparently experienced it as still another occasion in which her omnipotent wishes had been frustrated.

I could hear the voice with which I was speaking to myself at that moment in the meeting as the voice of a person experiencing a sense of impenetrable alienation from Mrs S; at the same time, I also recognised something else in that voice for the first time. It was the voice of a spurned lover. It occurred to me that Mrs S lived in a world in which two different forms of human experience each disguised the other.

At that juncture, I felt that I had arrived at the beginnings of an understanding of something about the relationship between Mrs S and me that I had not previously grasped. This new understanding did not serve to protect me from the chilling inhumanness that I had sensed in Mrs S and which I knew reflected important autistic and paranoid-schizoid elements in her personality; neither did it serve to dim the recognition that alongside these powerful autistic and paranoid-schizoid defences was a capacity for human love. I could at this point see in retrospect that it was in part my own lack of compassion for Mrs S and her wishes to comfort me as my wife that had led me to blind myself to the fact that her seeming absence of compassion represented a complex interplay of two powerful, coexisting aspects of her personality. She had been concerned about me and felt despondent that her love was unrecognisable to me (for example, as reflected in my not allowing her to comfort me). At the same time there was an important way in which Mrs S was unable to come to life as a human being and instead occupied a mechanical, omnipotent world of (1) relatedness to ‘autistic shapes’ and ‘autistic objects’ (Tustin, 1980, 1984) (for example, the mechanical, self-sufficiency involved in the sensation-world of exercise and diet) and, (2) paranoid-schizoid fantasies of entering me and parasitically living in me and through me.

I had been unable to live with, formulate and interpret for myself and for the patient the mutually obscuring interrelationship between being alive and being dead (i.e. the coexistence of depressive, paranoid-schizoid and autistic-contiguous [Ogden, 1989a, b] dimensions of the patient’s personality). Mrs S had loved me and had felt nothing whatever for me at the same time. I had experienced affection for her (which I came to recognise more fully in my experience of feeling like a spurned lover), but could not allow myself to feel warmth or at times even feel compassion for someone who was so clearly inhuman and inhumane (for example, in her treatment of her husband, her children and in her response to me, particularly after my father’s death).

Later in the session that I am describing, I said to Mrs S that I thought I had underestimated two things in our relationship: the amount of affection that there was and the degree to which no relationship at all existed between us. When I lost sight of one or the other facet of the situation, I failed to understand the totality of who she is and who we are together. I added that I thought that the degree to which it was possible for there to be no human tie between us had diminished in the time that we had known one another; but that it remained a considerable force to be reckoned with.

Mrs S responded by saying that I had never spoken to her in that way before. Previously, she had always felt that there was a way in...
which I was as cold as she was and that she could hear that iciness in my voice. She could not detect that
coldness in me just now. Mrs S went on to say that she did not believe that that iciness was gone, but at least it
did not dominate everything that occurred between us at the moment.

I understood this to be a statement of the patient’s feeling of relief in her sense that she could accept
understanding from me, which was something she never before had been able to do without immediately
attacking it, or more often, withdrawing into a state of autistic self-sufficiency or omnipotent paranoid-schizoid
defensive fantasy. My interpretation had denied neither her emotional deadness (her paranoid-schizoid and
autistic-contiguous modes of protecting herself nor her increased capacity to experience a human connection
to me (albeit very sparingly acknowledged by her).

Concluding comments

Four clinical discussions have been presented in an effort to illustrate ways in which the sense of aliveness
and deadness are generated and experienced in and through the intersubjective analytic third. In each of
the clinical situations described, the analyst attempted to create analytic meaning (‘analytic objects’) from that
which had been unconsciously present in, and powerfully shaping of, the analytic encounter, but had been
foreclosed from the analytic discourse. It was through the analyst’s use of his reveries, his unobtrusive,
quotidian thoughts, feelings and sensations (often seemingly unrelated to the patient) that specific, verbally
symbolised meanings were generated and eventually utilised in the interpretive process. In the four analyses
described, the particular quality of the experience of aliveness and deadness generated in the transference-
countertransference constituted an important intersubjective construction that reflected a central aspect of the
analyst’s and patient’s structurally structured internal object world.

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