Casement

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Forms of Interactive Communication

> It is a very remarkable thing that the *Ucs.* of one human being can react upon that of another, without passing through the *Cs.*
>
> (FREUD 1915: 194)[1]

There are times when the most important communication from a patient is unspoken. The process of a therapist's internal supervision can often help to identify this interactive dimension, so that it begins to make sense. Patients clearly demonstrate that the dynamics involved are by no means just theoretical, nor are they confined to analytic therapy. The forms of communication illustrated here are universal. Too often they are not recognized or they are seen as bewildering: the communication then remains unacknowledged or not understood.

COMMUNICATION BY IMPACT

Patients often behave in such a way that they stir up feelings in the therapist which could not be communicated in words. I have found it useful to consider this form of interaction under a general heading of *communication by impact.*

As a basic example of this, let us consider an infant's cry and the mother's response to its impact upon her. This is one of the most primitive ways by which one human being acts upon another, and is reacted to. A mother's response to her crying infant is usually to draw upon her maternal intuition, to sense the specific meaning of

this particular cry. To that end she will often put herself empathically in the infant's position, or in her own mother's position when she herself was crying in a similar way, in order to distinguish between one kind of crying and another.

In psychotherapy, therapists are often subjected to the unspoken cries of those who come to consult them. As with the mother and her infant, therapists have to be able to listen within themselves to draw upon their own experience of distress (whether that had been contained or not). If therapists persevere in their wish to understand, even when they are experiencing the confusion or pain which some patients induce in them, times will occur when the unconscious purpose of these pressures becomes apparent.

Some patients need to be able to have this kind of effect on the therapist, as an essential way of communicating what otherwise may remain unspeakable. When a therapist is able to understand the unconscious purpose of communication by impact, and can find ways of interpreting this, which help to make sense of it, then the patient can begin to feel that someone is really in touch with them—even with their own most difficult feelings.

EXPERIENCES RELATING TO ROLE-RESPONSIVENESS

I shall not attempt to define this concept prior to giving an example.

Unconscious Communication Evoked through the Therapist's Response to the Patient

Example 4.1

My first experience of being in any kind of supervisory role to another therapist was when I had just qualified as a psychotherapist. A colleague would sometimes let off steam to me by complaining about a particular patient of hers. This patient was described as coming from a good family, with parents who had maintained a good marriage, who had provided her with all that she could have needed in her childhood and in her education. The patient, however, was always complaining about her parents. She was described to me as "so persistently ungrateful" that the therapist felt exasperated, and she wondered whether she could continue to work with her. The therapist could not see that there was anything to complain about.

Discussion: I was aware of the possibility that I was hearing a straightforward example of countertransference, such as my training had taught me to beware of. It could have been that the patient had

become a transferential object to the therapist, representing some unresolved conflict of her own. What I knew of the therapist made me feel that this was not unlikely: I had gathered, from what she said about her family, that she sometimes thought of her own daughters as ungrateful.

Superficially, therefore, it looked as if there could hardly be a clearer example of countertransference, as it was first described (Freud 1910: 144-45). I sensed that my colleague also thought of her response to this complaining patient as a countertransference problem, to be dealt with outside the patient's sessions. This may have been why she was venting her exasperation on me, in order not to offload this onto her patient.

However, over a period of time, it began to dawn on me that my colleague could be missing an important communication, in this attitude which was so regularly being stimulated in her by this patient. The more I thought on this the more convinced I became that there was something else here, in addition to the classical phenomenon of countertransference.

The patient may have been unable to get across what it was about her parents that she was complaining of. Instead, she seemed to have *recreated in her therapist* the kind of attitude towards herself which her parents may have had. Perhaps they (like the therapist) had been blinded by an assumption that they had provided adequately for their daughter; and yet they may have been failing to recognize important ways in which they were shutting themselves off from the unmet needs of this complaining child. In order to communicate this the patient might have been able to touch upon an available countertransference resonance in her therapist, thereby evoking *in her* similar feelings and attitudes to those of her parents. If this really were such a communication, it could be a way of picking up from the patient something of what her parents may have been missing, and which the therapist had been missing too.

So, instead of having to treat this strong response to the patient solely as something belonging elsewhere in the therapist's life (which in one sense it did), it could also be looked upon as conveying an intangible aspect of the patient's relationship to her parents, about which she had been complaining. The parents had been shut off from this patient much as the therapist had come to be. Perhaps, in response to the patient's urgent need to get this across, the therapist had become involved in an unconscious reenactment of the complained-of parents. In his paper "Countertransference and Role-Responsiveness," Sandler was later to describe this process as "actualization" (Sandler 1976).[2]

When I discussed this possibility with my colleague she was able to recognize the interactive communication here, which formerly she had been missing, and she started to listen to her patient differently. In so doing she became less shut off from the patient, and less caught up in her own feelings of intolerance towards her. Heimann (1950) and Little (1951) have both pointed out that the analyst's feeling responses to the patient may contain valuable cues to the patient's unconscious communications. Sandler illustrated how the analyst can be drawn into a behavioral interaction. In "Countertransference and Role-Responsiveness" he writes:

> I believe such "manipulations" to be an important part of object relationships in general.... In the transference, in many subtle ways, the patient attempts to prod the analyst into behaving in a particular way and unconsciously scans and adapts to his perceptions of the analyst's reaction. (Sandler 1976: 44)

It is all the more important, therefore, that we should be able to distinguish that part of a therapist's responses which offers clues to the patient's unconscious communication from that which is personal to the therapist. In order to make this distinction, at the time of the clinical episode quoted, I suggested we might speak of a "diagnostic response" as compared with a "personal countertransference" (Casement 1973).

Boredom as Communication

Example 4.2

For some months, in the course of a long analysis, I found myself regularly feeling bored by one particular male patient. I silently explored this as fully as I could to see if my feelings were simply some personal countertransference to my patient, as a transferential object, thinking here of countertransference in the sense described by Reich (1951). But even after this self-scrutiny, my feelings of boredom continued to occur in many of the sessions with this patient.

When I monitored this boredom more closely, I came to recognize I was responding to the fact that the patient was not relating to me. He seemed to be speaking to himself, as if I were not present; but this was not the whole of it. The patient treated me as physically present but emotionally absent. He was assuming that I was not interested, although this was not normally how I felt towards him. I could then see that the quality of his relating to me was as if to someone whose interest he could not engage, or who was unwilling to be engaged. This offered me a fresh clue.

What then stirred in me was a clear image of this patient at the time when he had been in a mental hospital. He had told me how his mother

used to visit him regularly. She claimed to be concerned, and yet she continued to rationalize why her son had to remain in hospital. (He would have been allowed home if his parents had been prepared to look after him.)

The patient's presence in hospital was due to a prolonged agitated depression. This in turn was largely activated by the family's readiness to close ranks against this child, who had come to feel that life was not worth living. The parents did not seem to be prepared to let themselves be in touch with, or to be touched by, the patient's depression and despair—or by his need to be allowed home, rather than being left indefinitely in a mental hospital until he was "better." The parents were wanting to ignore the main reason for their son being left there. This was because he had nowhere else to go other than to his home, where his parents felt that they would not be able to cope with him in this chronic state.

With this reactivated memory as my cue, I began to wonder whether my patient might be reenacting with me the empty relating that he had so often sat through while he remained in hospital. He had talked *at* his mother, who had barely listened. His mother, in her turn, had talked *at* him rather than *to* him.

When I began to refocus my listening to the patient, in this new context, I could recognize many other indications which confirmed this impression. I became able to point out to the patient how he was speaking to me, as if he did not expect me really to be interested or to be ready to take seriously anything he said. I wondered whether this may have been how it used to be during his mother's visits to him in the hospital, which sounded as if they had been just as empty of meaningful relating.

Once I had been able to interpret this emptiness in the transference, the patient began to speak to me and to relate to me in a way that began (for the first time) to be invested with meaning. The transference stopped being a shallow relating, as if to a physically present but emotionally absent mother. Instead, the patient began to relate to me as to someone who was emotionally as well as physically present; and I stopped being troubled by boredom when I was with him.

AN EXPERIENCE OF PROJECTIVE IDENTIFICATION

Although I had struggled to understand the concept of projective identification from what I had read about it, as in Klein (1946) and Segal (1964) for example, it was not until I recognized being on the receiving end of this particular form of interactive communication that I began to understand it clinically. I shall again give an example before trying to conceptualize the dynamics illustrated.

Example 4.3

I was asked to see a couple, Mr. and Mrs. T., because of the wife's frigidity.

They were both in their thirties. For the past five years Mrs. T. had been unable to allow intercourse on account of what she described as "gynecological pain." This had been causing great stress in the marriage. There was a serious risk of the couple splitting up.

Medical examinations and tests had revealed nothing, but the referring doctor had mentioned that Mrs. T. had been sterilized three years earlier. He wondered whether this might have left post-operative adhesions. However, the gynecologist thought that it would be pointless to reopen the operation scar, as this would probably only cause fresh adhesions. She could end up no better.

In the initial consultation I saw Mr. and Mrs. T. together, as they had been referred as a couple and had asked to come for help with their marriage. Mr. T. took little part in this consultation. Mrs. T., on the other hand, told me her story. They had been married about ten years, having known each other for several years before that. They had spent the first five years of the marriage getting a house and decorating it, in preparation for beginning a family.

After this introduction, Mrs. T. told me about their two children. They had had a son and a daughter. She then told me the painful details of her discovery that there was something wrong with their first child. When he was six months old he began to scream continuously unless sedated. For nine months she nursed him until he died. Mrs. T. was seven months pregnant with their second child at the time.

After attending the funeral of her son, she "felt tearful but held it in." She had never cried since then. She just felt numb. The second child, a daughter, was also born apparently normal. She died ten months later, of the same constitutional brain disorder as had her brother. It was after this that Mrs. T. was advised to be sterilized.

Internal supervision: What was most striking, during the telling of this terrible sequence of pain and loss, was that Mrs. T.'s face and tone of voice remained wooden and lifeless. Even when she was talking of the children's illness, and slow dying, she showed no feelings at all. But my own feelings, upon listening to her, were nearly overwhelming me. I was literally crying inside.

I wondered about my response. I knew I would be moved by any account of a child's death. Was this some personal countertransference problem, only to do with me? I had to consider this as a real possibility. But, as I looked into this further, I began to realize why I was being so affected. If Mrs. T. had been crying her own tears I would not be feeling so overwhelmed. What was producing this effect upon me had something to do with her inability to show any expression of her own feelings.

I once again called upon my provisional concept of a diagnostic response. I postulated (to myself) that the intolerable pain of losing both her children in this way, followed by the sterilization (losing

any chance of having other children of her own), had been too much for her. To survive these intolerable experiences, she may have converted the psychic pain belonging to them into gynecological pain. Perhaps this symptom continued to express, somatically, the repressed feelings related to those unbearable losses, which had been so closely associated with that part of her body.

Mrs. T. did much more than project her feelings onto me. She made *me* feel what *she* could not yet bear to feel consciously within herself. And the manner of this projection was not impossible to identify. I could see that it had been the patient's own lack of emotion that had been having the greatest impact upon me. As a result, I had been feeling in touch with tears which did not altogether belong to me.

> After recognizing this response in myself I was able to draw Mrs. T.'s attention to this. I said to her that there was something rather strange happening in the session. She had been telling me the details of her experience with her two children, but she had shown no feelings about this. I, on the other hand, had felt near to tears *as if for her.* She replied that she frequently needed to talk about the death of her children, but people had begged her not to as it affected them in much the same way as I had just described. She had relied upon not feeling anything about these experiences. It would probably be too painful. Instead she had kept herself active, to keep her mind occupied with other things.

Discussion: I felt sure that, if Mrs. T. could be helped to be in touch with her own crying inside, perhaps to be able to cry openly instead, she would not need her body to continue to be in pain. The subsequent course of her brief therapy fully confirmed this diagnostic impression. As she became able to bear to be in touch with the previously repressed psychic pain, her gynecological pains began to fade away. She was able to enter into the process of mourning which had been so long delayed.

PROJECTIVE IDENTIFICATION AS COMMUNICATION

Unfortunately, it is not easy to get a clear understanding of projective identification from the literature alone, as this concept has become complicated by the varied uses to which it has been put.[3] However, through the above experience and others like it, I became able to recognize clinically a part of what projective identification is about—how it happens and the unconscious purpose of it.

One of the uses of projective identification that many people

experience clinically (whether they know it or not) is a form of affective communication.[4] This is especially relevant when what is being communicated is beyond words, relating to unspeakable experiences or to preverbal experience.

In order that therapists (and those in the other helping professions) may be more able to respond therapeutically when they encounter this form of unconscious communication, I shall endeavour to clarify this particular aspect of projective identification. I shall not discuss the other forms of this here, but I refer briefly to these in the footnotes. My description will therefore be incomplete, but I trust that it will be clear enough to encourage therapists to recognize the importance and implications of this key interactional dynamic. With the help of this understanding, it becomes possible to contain some patients who might otherwise remain uncontained. Without it, the meaning of the helper's feelings of stress may be misunderstood, and some patients will not find the help they look for. This frequently results in missed opportunities for better understanding of patients in distress.

I find it helpful to think of projective identification as a more powerful form of projection. It is well known that when projection (simple) is operating, the projector disowns some aspect of the self and attributes this to another. Evidence of that projection is usually to be noticed in the projector relating differently to the other person (or outside world) in terms of what has been projected. The recipient, or observer, may otherwise be quite unaware of any projection operating. What is foremost here is the projector's need to disown some aspect of himself.

When projective identification is used *as a form of affective communication,* the projector has a need (usually unconscious) to make another person aware of what is being communicated and to be responded to. The sequence is roughly as follows: (1) the projector experiences unmanageable feelings, such as an infant might have; (2) there is an unconscious fantasy of putting this unmanageable feeling-state into another person, such as the mother, for this to be disposed of or made manageable; (3) there is an interactional pressure, such as an infant's cry, with the unconscious aim of making the *other* person have these feelings instead of the infant or patient; (4) if this communication by projective identification is successful in reaching the other person, an affective resonance is created in the recipient whose feelings take on a "sameness" based on identification. This affective identification can then be thought of as being brought about projectively by the projector and introjectively by the recipient.There are several different possible

results to this unconscious endeavor. If the recipient is open to the impact of the interactional behavior, or other non-verbal pressures from the projector, an affective communication is achieved. What is communicated may be to do with any state of feeling that is experienced as unmanageable by the projector; acute distress, helplessness, fear, rage, contemptuous attack upon the self, etc. The feelings being communicated are felt by the recipient.

What is then needed (for a therapeutic response to be possible) is for the recipient, the mother or the therapist, to be more able to manage being in touch with these feelings than the infant or patient had been. When this response is found, the previously unmanageable feelings become more manageable. They become less terrifying than before, because another person has actually felt them and has been able to tolerate the experience of those feelings. The projector can thereafter take back those feelings, now made more manageable; and along with this can take in something of the recipient's capacity to tolerate being in touch with difficult feelings. The unconscious hope, implied in the use of projective identification as communication, thereby meets a therapeutic response from the mother or therapist.

However, this unconscious hope is not always met. For example, if the recipient remains shut off from this attempt at communication or fails to recognize the interactive pressures as a form of communication, there will be no therapeutic response. The projector then experiences the projection as thrown back; and the unmanageable feelings being projected remain unmanageable. Likewise, if the recipient experiences (but cannot bear being subjected to) the feelings being projected, the projector will experience the recipient as thrown off balance by what is being projected; and the sense of these feelings being unmanageable is traumatically confirmed. Instead of the unconscious hope being met, there is a new state of hopelessness and despair (Bion 1967b: Chapter 9).

In Chapter 7, I present a clinical sequence which illustrates these issues more extensively.

COMMUNICATION THROUGH DEFENSIVE BEHAVIOR

One way of seeking refuge from the pain of being badly treated is to identify with the aggressor and to treat another person in a similar way, thereby inducing in someone else the unwanted pain

of that experience (A. Freud 1937). There are times when a patient will unconsciously recreate in a therapist feelings that belong to the experience in question, and which the patient is trying to "get rid of" in this way. It is therefore not only unmanageable feeling-states that come to be evoked in the therapist by means of impact behavior; this may include aspects of the patient's unbearable experience. (Kleinians would probably regard this too as a form of projective identification.)

If a therapist recognizes when he is being subjected to this kind of interactive pressure from a patient, it is often possible to find a clue to such unconscious communication in his own affective response to the patient's behavior (see King 1978).

Example 4.4

A patient, during the early stages of an analysis, noticed that I had been using my library (which is an integral part of my consulting room). I had been looking up references for some work I was doing, and I had not tidied up after pulling out books and journals from the shelves.

The patient said he could not live with his books in such a state of mess. He would want to have the books all in order, and he wondered how I could put up with my shelves like that, day after day.

That evening I thought about the dilemma that I felt placed in. I wanted to tidy my shelves; but if I did this straight away the patient could feel that he had made me tidy them, and I felt uneasy about it looking as if I had obediently done what I had been told to do. Of course, I could avoid that discomfort by leaving everything as it was; but I still wanted to tidy the shelves.

For a while I felt paralyzed by this apparently trivial issue. The only solution was to do what made most sense to me. I tidied the books; but, when I came to the journals that I had not finished using, there remained an element of the same dilemma. Again, I did what suited me. I left the unfinished journals on their side, lying over books on the shelf.

When the patient came to his next session he looked at the changes on the shelves. After some thought, he exploded in a tone of voice quite unlike anything I had heard from him before: "PATHETIC!" After a silence he elaborated further. He thought that I could not have chosen a more ridiculous compromise. He said if I didn't want to feel pushed around by him it would have been better to have left the shelves as they were. Perhaps I liked them like that. If, on the other hand, I actually wanted to tidy them why on earth not finish the job? As it was, he concluded, I had left a few journals not tidied away as a "token gesture of independence." Why hadn't I just done what I wanted to do?

Internal supervision: As I thought about the patient's perception of what he saw as my compromise, I realized I had been in a double-bind[5]

after his last session (Bateson et al. 1956). This had seemed insoluble until I chose to resolve it in the only way that allowed me to be free. I had done what had suited me, leaving out the journals I was still working on. The patient expected me to have remained in the double-bind, not able to resolve it. He also assumed that I could not let myself do what I wanted to do.

I began to realize the significance of this interaction. It had already become clear, in the short period of his analysis so far, that this patient had been regularly placed in double-binds by his mother; and he had not been able to find a way out of the paralysis which that behavior induced in him.

I said I thought the issue was about being in a double-bind, and I told him that I had been aware of being in a dilemma about tidying the shelves. He was right in supposing I wanted to tidy them; but he also assumed I had been unable to do what I wanted. I thought that this assumption was because he had so often not been able to cope with similar double-binds from his mother. He had not found a way out of that through doing what *he* wanted to do.

The patient recognized what I was describing. He said his mother was probably "the double-binding mother of all time." Whatever he did, his mother always found some way of saying it was all wrong. He had never found any way of dealing with this. He also agreed he had been doing to me the kind of thing his mother used to do to him, but he could not see that I had found any way of dealing with his double-binding of me.

I told him I was still using the journals which were not put away, so I had kept these out. Equally, I wanted to tidy the rest and I was glad to have been prompted to get round to this.

What followed helped us to see that the patient had been unconsciously testing me. He was relieved to know I had felt doublebound. He also thought it was no accident he had selected an issue of untidiness. His mother had frequently made him tidy up, or clean; and he could never satisfy her. There was always something his mother would criticize him for, however careful or thorough he was.

Discussion: In this unconscious interaction, the patient had been doing to me the kind of thing his mother had so often done to him. (The defensive behavior here was that of identification with the aggressor.) Through my response to his pressures I had felt something of what he used to feel from his mother. This helped me to recognize what it could have been like for him as a child, with his mother. He was subsequently able to discover that he too could do what made sense to himself, rather than remain constantly paralyzed by trying to please his unpleasable mother; and he began to establish a separateness from her which he had never before dared to attempt.

A COUNTERTRANSFERENCE RESPONSE TO IMMINENT STRESS IN THE ANALYSIS

Example 4.5

A patient, who was leading up to a crisis in her analysis, had been expressing her fear of "going to pieces or going mad," and how she might be left permanently vulnerable because of that experience. Also, she might never really recover from it.

Without recognizing why at the time, I acted upon a countertransference impulse—meaning to help this patient find the courage not to run away from what she was fearing. I mistakenly told her I had found that a lasting strength for me had grown out of daring to face my own deepest fears, even the fears of going to pieces or of going mad.

The patient read my comment (at some level quite correctly) as expressing unconscious anxiety of my own. She took this to mean that I was warning her not to go further into this experience in her analysis

Internal supervision: It would, of course, have been far better if I had continued to analyze the patient's anxiety about whether I could help her through the experience that she feared. By resorting to this non-analytic procedure I am failing to hold her analytically at this moment.

Now, quite apart from any transference implications for the patient, it is likely she will need me to attend to the reality basis for her subsequent fears. She gave me clear confirmation of this need in her next session.

PATIENT: I had a terrible dream: *I was going up a mountain in a cable-car. Suddenly it broke down and stopped. I was stuck half-way up the mountain, unable to go any further and unable to go back. I was stranded. What made it much worse was that the door of the cable-car kept on swinging open. It was all glass in a metal frame—a casement frame.*

Internal supervision: I was hearing of the patient's journey being in jeopardy from something that had broken down. The day residue referred to in this dream seemed obvious: there was a door swinging open, and the frame of the cable-car was made of glass (too transparent). The frame that she described is (in England) called a "casement frame."

I was immediately reminded of the analytic frame and of what I had told her about myself, in trying to tell her that I was familiar with the kind of experience she feared. I realized this was now causing her to be fearful for her analysis.

ANALYST: I cannot fail to see the references to what I told you about

myself, and my familiarity with the experience of going to pieces. This has not helped. Instead, it has made you anxious about whether I can cope with what may lie ahead in your analysis—so anxious that you seem to be wondering whether you can even dare to continue your analysis with me.

PATIENT: I feel you are warning me not to go any further towards that experience. In fact, I think you are telling me you might not be able to cope. Perhaps you do feel threatened and need to warn me not to go on. But I also can't go back.

What followed during this session, and the sessions after it, was a period of acute anxiety with the patient having to test and retest my capacity to hold her analytically through whatever was still to come in her analysis. She went into an intensely frightening sequence of sessions, during which she eventually did experience herself as "going to pieces." She also dreamed of her foundations breaking up, as if from an earthquake. But she did not get into this reliving of her childhood experience of disintegration until after we had done the necessary analytic work on her dream, which so clearly showed the implications for her in my attempt at reassuring her and the need for me to recover my analytic holding of the patient.

Discussion: In this sequence, I had to accept that I had provoked what followed in the analysis. But I do not think this accounts for it all.

The patient had already indicated she felt there was a crisis brewing up for her. When she later experienced going to pieces in the analysis, the sense of her foundations being threatened was no doubt linked with what I had introduced in the analysis, by the uncalled-for element of self-exposure. Nevertheless, I do not think this patient would have been able to go on with her analysis if what followed was entirely caused by my break in the analytic frame, which usually preserves the relative anonymity of the analyst from intruding upon the analytic process. The dreaded experience also belonged in her own early life-experience, and had to be lived through in the analysis before she could deal with her own "fear of breakdown" (Winnicott 1970).

Comment: I have noticed that several times, and with different patients, I have fallen into a sequence similar to the one above. There is no doubt that some countertransference is always operating when I deflect a patient, or try to reassure, particularly as I know so well that this does not work. So why does it keep on happening?

It occurred to me during the later session, when this patient told me of her earthquake dream, that I had recently heard about areas in the world where earthquakes are common. Apparently it has been noticed there that animals start to behave strangely, dogs barking and geese cackling, shortly before there is an earthquake. It is the usual practice, in such regions, to seize the children and to get them into the open (for safety) in case there is an earthquake threatening.

Perhaps there is a similar function performed by the countertransference: but in this case (and in others) I had missed the moment of recognition. I now think that the impulse to reassure is not just an important cue for caution. Sometimes it may also be an early pointer to some kind of earthquake-experience which may be imminent in the analysis or therapy. So, if we could listen to this impulse to reassure, like those people who respond to the early warnings they receive from animals, we could be better prepared for what may follow.

One further encounter with the interactive unconscious that I wish to describe, relates to Winnicott's concept of the patient's use of the analyst's failures. He writes of this in a number of different places (e.g. Winnicott 1958: Chapter 22; 1965b: Chapter 23).

A THERAPIST'S FAILURE AND THE PATIENT'S PAST HISTORY

Example 4.6

A therapist was seeing a patient in three-times-a-week psychotherapy. The patient (whom I shall call Miss G.) had been traumatized as a child by her mother's repeated absences, in hospital with cancer, and (at the age of four) by her mother's death.

From the beginning of this treatment the therapist was kept firmly engaged by this needy patient, even though Miss G. frequently failed to turn up for sessions; and for a long time her silence at the beginning of sessions had exerted an enormous pressure on the therapist to speak first.

In this phase of the treatment the therapist listened closely to what she was thinking and feeling, during these silences or unexplained absences. She realized she was left not knowing what was happening to the patient, and (on some occasions) she even wondered whether she would ever see Miss G. again.

Over a period of time the therapist came to wonder whether her patient was making her feel a sense of abandonment and uncertainty, similar to that which Miss G. had probably felt during her mother's unexplained absences in hospital, and after her eventual death. This is another example

of communication by impact, the therapist responding to the powerful effects on her caused by the patient's absences and/or silences.

Listening to what the patient was making her feel in this way, the therapist was able to interpret to Miss G. her awareness of how unbearable it must have been when she was so often left in this state of not knowing what was happening to her mother, and what had later happened when she never saw her again. The patient was gradually able to acknowledge that this made sense to her. It also helped her to forego most of her opening silences in sessions; though, at times of deepest despair, she would again resort to lateness (or absence) now knowing that this would be understood by her therapist as a sign of distress.

Comment: We can see here how Miss G. was able to communicate feelings which were beyond words, but which had been heard and understood because of the impact they made on the therapist. The therapist made good use of her knowledge of the dynamics of projective identification, and the patient remained in therapy even through times of greatest despair. The therapist also understood how important it was to Miss G. that she (the therapist) should be regularly there for the sessions, whether the patient came or not. Regularity, reliability, and on-going constancy were carefully maintained by this therapist for her patient.

> One morning the therapist overslept.[6] The patient came to the therapist's consulting room for her early morning session, only to find herself shut out. She remained outside the locked door until the cleaner arrived. For the rest of her session time she was looked after by this cleaner, who expressed particular concern about the therapist's absence as it was "so unlike her not to be here." Inevitably, Miss G. felt something really serious must have happened. Perhaps there had been an accident. Perhaps her therapist was in hospital. Maybe she had died.

Discussion: The patient's experience of separation and her increased need of the absent mother had come to be deeply linked in her mind. So, after her mother's death Miss G. began to believe that it could have been the intensity of her need for her mother that had caused her to leave, and eventually to die. In the therapy itself there had now come to be a dramatic repetition of this same sequence, which clearly demonstrated her fantasy that it might be her dependency and need which "caused" the person she depended upon to be absent, perhaps to have become ill or to have died.

It is uncanny how this therapist unconsciously reproduced a real failure in the therapy which was so close to the experience of her patient's own childhood trauma. How is it, then, that we sometimes fail a patient even when we are so carefully trying not to? When

this happens it can threaten the whole therapeutic relationship. And yet, when a patient is confronted by a real issue like this, about which he or she can be genuinely angry with the therapist in the present, it can equally become a pivotal experience in the therapy.

It could be that any recreation of an earlier trauma in the therapy comes about partly through an interplay of personal countertransference and role-responsiveness. Winnicott, however, speaks of a further dimension to this unconscious interaction:

> Corrective provision is never enough. What is it that may be enough for some of our patients to get well ? In the end the patient uses the analyst's failures, often quite small ones, perhaps manoeuvred by the patient ... and we have to put up with being in a limited context misunderstood. The operative factor is that the patient now hates the analyst for the failure that originally came as an environmental factor, outside the infant's area of omnipotent control but that is *now* staged in the transference. So in the end we succeed by failing—failing the patient's way. This is a long distance from the simple theory of cure by corrective experience. (Winnicott 1965b:258)

Later, in relation to his own patient in this paper, Winnicott adds:

> I must not fail in the child-care and infant-care aspects of the treatment until at a later stage when *she will make me fail* in ways determined by her history. (Winnicott 1965b: 258-59)

Miss G. may have unconsciously prompted her therapist to fail her "in ways determined by her history." So, at a time when she was being sensitively and consistently held in the therapeutic relationship (with unconscious reminders of a good holding-relationship that had existed earlier with her mother), this therapist became involved in a real failure of her patient. The nature of this failure had a terrifying similarity for the patient to her own childhood trauma. She consequently experienced, in the present with her therapist, her own obliterating anger that belonged to the original trauma.

The patient was able to find in this experience a real opportunity to *use* her therapist to represent the mother who had "failed" her, who had inexplicably shut her out by not being there. She could now begin to attack her therapist with her own strongest feelings about that earlier (and this present) failure, with her therapist surviving these attacks of rage upon her.

In his paper "Use of an Object and Relating through Identification," Winnicott stresses that the key to this survival is to be found in the patient discovering that the analyst (or therapist) has a strength that is not "created" by the patient's fantasy or projection

(Winnicott 1971: Chapter 6). Miss G. could only begin to modify her unconscious fantasy, that it had been her own anger at her mother's absences which had seemed to have been the cause of her death, through subjecting her therapist to her most intense feelings about that absence with her therapist (ultimately) not retaliating or collapsing, but surviving.

VARIOUS ASPECTS OF COUNTERTRANSFERENCE

If we are to suppose, as I do here, that there is a level of communication which is achieved through some interactive responsiveness between patient and therapist, it is essential that there should be ways of distinguishing between different kinds of response to the patient.

A great deal has been written on this. I shall not, however, endeavor to offer any systematic review of the literature on countertransference. This has been done thoroughly by others.[7] I wish only to outline some of the different ways in which countertransference has been written about, in particular those ways which throw light upon the examples given above.

1. Countertransference can be regarded as "a result of the patient's influence on his [the physician's] unconscious feelings" (Freud 1910: 145), for which the analyst should use self-analysis to resolve or seek further analytic help.

2. M. Balint (1933) (in Balint 1952: Chapter 12) and A. Reich (1951), likewise, both emphasized the fact that there are times when an analyst experiences a *transference response* to the patient. This can occur when a patient comes to represent some unresolved aspect of a significant relationship in the earlier life of the analyst or therapist; and this will threaten therapeutic work with that patient unless it is resolved through further self-analysis of the therapist

3. Winnicott, in his provocative paper "Hate in the Counter-transference," refers to a truly objective countertransference. For instance, he says: "A main task of the analyst of any patient—is to maintain objectivity in regard to all that the patient brings, and a special case of this is the analyst's need to be able to hate the patient objectively" (Winnicott 1958: 196). And later he adds:

> The analyst's hate is ordinarily latent and is easily kept so. In analysis of psychotics the analyst is under greater strain to keep his hate latent, and he can only do this by being thoroughly aware of it. I want to add that in certain stages of certain analyses the analyst's hate is actually sought by the patient, and what is then needed is hate that is objective. If the patient seeks objective or justified hate he must be able to reach it, else he cannot feel he can reach objective love. (Winnicott 1958: 199)

4. Paula Heimann stressed the "counter-" part of countertransference, seeing this as the analyst's response to the patient's transference. She emphasized that: "the analyst's emotional response to his patient within the analytic situation represents one of the most important tools for his work. The analyst's counter-transference is an instrument of research into the patient's unconscious" (Heimann 1950: 81). She later continues:

> I would suggest that the analyst along with this freely working attention needs a freely roused emotional sensibility so as to follow the patient's emotional movements and unconscious fantasies. Our basic assumption is that the analyst's unconscious understands that of his patient. This rapport on the deep level comes to the surface in the form of feelings which the analyst notices in response to his patient, in his "counter-transference." This is the most dynamic way in which his patient's voice reaches him. (Heimann 1950: 82)

5. Pearl King, in her paper "Affective Response of the Analyst to the Patient's Communications," tries to get free of the confusingly different uses of countertransference:

> It is thus of central importance to distinguish between countertransference as a pathological phenomenon and the affective response of the analyst to the patient's communications, particularly his affective response to the various forms that the patient's transference takes. (King 1978: 330)

WHAT BELONGS TO WHOM?

What most writers agree upon, in their differing ways, is that therapists are affected by their patient's impacts upon them, whether this be due to a patient's personality, a patient's transference, or a patient's manner of being. Often, the therapist's response to this may indicate something that has only to do with the therapist. At times, there may be elements also of unconscious communication from the patient. It cannot always be rigidly defined as countertransference or not, as pathological or not.

Once it is accepted that there can be an interactive communication between patient and therapist, a number of technical issues are immediately raised. I wish to concentrate on problems relating to the question: "whose pathology is operating at any given mo-

ment, the patient's or the therapist's, and how can we distinguish one from the other?"

Even after a personal analysis, any therapist is still liable to use the defenses of projection and denial, particularly when under pressure. So, the first step must be to monitor one's feelings, in any therapeutic interaction, for personal countertransference. Even though this may be triggered by something about the patient, a therapist must first accept what belongs to himself. The next step is to determine whether a patient is prompting the therapist to feel or to respond in a given way, and if so how and to what unconscious end might that be?

THE THERAPIST'S RESONANCE TO THE PATIENT

A therapist's receptivity to the patient's unconscious communication becomes manifest in his resonance to interactive pressures. This resonance results from a matching between what is personal to the therapist and what comes from the patient. How responsive a therapist can be to patients, at this interactive level of feeling compared with cognitive understanding, will depend upon two things in particular about the therapist.

First, he or she needs to have access to these unconscious resonances across as wide a range of feeling as possible. Therapists do not have to remain limited to their own experiences, their own ways of being and feeling. It is possible that each person carries the potential to feel all feelings and to resonate to all experiences, however strange or alien these may be to their conscious selves; but, whenever there are unresolved areas of repression or continued disavowal, there will continue to be degrees of feeling that remain deadened and unresponsive. The expanding of a therapist's range of empathic resonance is a major gain from analysis, and this needs to be a continuing process.

Second, every therapist has to learn to be open to the "otherness" of the other—being ready to feel whatever feelings result from being in touch with another person, however different that person is from themselves. Empathic identification is not enough, as it can limit a therapist to seeing what is familiar, or is similar to his own experience. Therapists therefore have to develop an openness to, and respect for, feelings and experiences that are quite unlike their own. The greater freedom they have to resonate to the unfamiliar "keys" or dissonant "harmonics" of others, the more it will enhance their receptivity to these

unconsciously interactive cues that are often central to an understanding of patients.

A REVIEW OF THE EXAMPLES

In the examples given we can see different admixtures of what belongs to the therapist and what comes from the patient. The therapist who complained about an ungrateful patient was aware of a similarity between the patient and her daughters. This awareness prompted her to be cautious, but this caution also inhibited her. Once she could recognize that her resonance to the patient's ingratitude was also a response to something from her patient, she could begin to see that her attitude to the patient had become similar to that of her patient's parents.

My boredom, with the second patient, did not lift however much I looked for reasons within myself. Once I recognized a similarity between that analytic relationship and an empty kind of relating in this patient's earlier life, I was able to understand the feelings that this patient had so regularly engendered within me.

When I was with the woman whose children had died, the intensity of my feelings might have belonged only to me. Once again, however, the patient's contribution to my response (in the absence of her own feelings) led me to be confident that there was also an unconscious communication through her evoking those feelings in me.

The fourth example, when I tidied my bookshelves, is different. I was placed in a situation in which I could not do right in the patient's eyes. Here the feeling was of being trapped, or paralyzed, which helped me to recognize that the patient had unconsciously maneuvered me so that, whatever I did, I could not escape criticism—even ridicule. I had a hunch that the patient may have been identifying with his mother, placing me in a situation similar to that which he had experienced in childhood. It was only possible to explore this possibility by sharing with the patient my perception of that experience, and how I had set about resolving it.

One factor which these four examples have in common is that we are able to identify, in each, some contribution from the patient towards the therapist's responses. This is important because, if we can see what evokes these responses to the patient, we are on surer ground when we postulate that there may be some communication being conveyed by means of this interactive behavior.

In the fifth example, when I tried to reassure the patient, I was

clearly responding to some unconscious anxiety about what lay ahead in this patient's analysis. This could have been more clearly anticipated if I had recognized the diagnostic element in my countertransference response to the patient. Consciously I felt well equipped and prepared for what lay ahead. Unconsciously I responded like those animals that sense an imminent earthquake.

The last example is more problematic. One view could be to regard this therapist's oversleeping simply as an acting out against the patient. We must not ignore this possibility. My impression, however, is that it becomes more meaningful when this is also considered as a further example of interactive communication. I find Winnicott's theoretical statements about a patient's use of the analyst's failures convincing, but I acknowledge that it would be wrong for any therapist to shelter behind this as a way of denying his own part in failures encountered in an analysis or therapy.

THE ISSUE OF INTENSITY

An interesting idea, which seems to be missed by other writers, arises from this notion of interactive communication. If it is valid to think of patients using communication by impact or projective identification, as a means whereby the unspeakable can be conveyed to the therapist, then there will be times when the feelings involved are going to be very intense. Sometimes it may be the *intensity* that is the main point of the communication. So, if therapists are to be adequately in touch with this, they will find themselves also experiencing feelings with a similar intensity.

In contrast to this, Heimann describes the more usual view when she says:

> Since... violent emotions of any kind, of love or hate, helpfulness or anger, impel towards action rather than towards contemplation and blur a person's capacity to observe and weigh the evidence correctly, it follows that, if the analyst's emotional response is intense, it will defeat its object .... The analyst's emotional sensitivity needs to be extensive rather than intensive, differentiating and mobile. (Heimann 1950: 82)

My experience with patients has led me to disagree with this view. The analyst or therapist has to learn to tolerate being in touch with violent emotions so that they do not "impel towards action," rather than to suppress these feelings. And, when the capacity for clear contemplation or observation is blurred, the possible communication in this too should be looked for when sufficient clarity of thinking has been recovered.

THE USE AND MISUSE OF COUNTERTRANSFERENCE IN INTERPRETATION

Some therapists interpret almost directly from their own feelings about the patient; but if a therapist says to a patient (for example), "You are making me feel...," this can suggest that all responsibility for what the therapist is feeling is being placed upon the patient.

Similarly, it is unwise to subject a patient to samples of self-analysis when trying to understand (or to explain) some erroneous interpretation, or other disturbing activity by the therapist. That should be the therapist's private affair. Heimann therefore said that there should be no confessions by the analyst to the patient. However, she was clear that: "The emotions aroused in the analyst will be of value to his patient, if used as one more source of insight into the patient's unconscious conflicts and defenses" (Heimann 1950: 83–4).

Margaret Little on the other hand, considers that there are occasions when it can be of great benefit to a patient if the analyst is open about *some* of his or her feelings:

> In the later stages of analysis then, when the patient's capacity for objectivity is already increased, the analyst needs especially to be on the look-out for counter-transference manifestations, and for opportunities to interpret it, whether directly or indirectly, as and when the patient reveals it to him. Without it patients may fail to recognize objectively much of the irrational parental behaviour which has been so powerful a factor in the development of the neurosis, for wherever the analyst does behave like the parents, and conceals the fact, there is the point at which continued repression of what might otherwise be recognized is inevitable. (Little 1951: 38)

The above examples illustrate some occasions when a cautious honesty about feelings evoked by a patient can enable the therapeutic process. This is less likely to be intrusive if we can identify the patient's contribution to this, as for instance in Example 4.3 where I told the patient about the suppressed crying.

However, when it is not yet clear whether there is any real communication from the patient in the therapist's responses, the patient should not be burdened with uncalled-for evidence of what the therapist is feeling. I can illustrate this most easily from Example 4.2. There, I did not think it fitting to tell the patient that I was feeling bored. So, rather than interpret direct from the

countertransference (which is always inadvisable) I was able to listen more alertly; and from that new alertness I could begin to recognize the empty relating which had been so powerfully acting upon me to evoke this boredom.

It is a sound principle that countertransference should not intrude upon the analytic process; but this should not deter us from using our resonance to the patient to aid our further listening. Any subsequent interpretation that is based upon interactive communication needs to be linked to some identifiable cues from the patient, that he or she can recognize when made aware of them. When we cannot identify these cues, this usually indicates that there are not yet sufficient grounds for an interpretation if it is arrived at solely through the therapist's responses to the patient.

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Listening from an Interactional Viewpoint: A Clinical Presentation

In the last chapter I gave an example of a therapist reenacting a traumatic element of the patient's childhood experience (Miss G. in Example 4.6), where it was possible that this reenactment grew out of the therapist's unconscious response to unconscious cues from the patient. I shall give here a more detailed illustration from an analysis in which, during the reported sequence, similar dynamics gradually emerged.

I also use this clinical sequence as a further illustration of learning to use internal supervision. I therefore follow the analytic process at three levels: (1) the analytical dialogue—what the patient and I said, in sequence, in each session; (2) internal supervision—what I was thinking, in the session, and how I arrived at each intervention; (3) hindsight—a commentary on some of what I later realized I had missed at each point in the session. Much of this hindsight occurred to me when writing notes after each session. I selected this particular week for making fuller notes than usual because I knew I was currently having difficulties in this analysis, and I was trying to sort out what was happening.

We will see that I made a number of mistakes in this sequence, which at the time seemed quite inexplicable. Gradually I began to recognize, and to respond to, the patient's unconscious cues which helped me to recover an analytic holding in the analysis. The following day, the patient made a surprising use of this recovery, reexperiencing in the session a very early trauma. With hindsight,