object, meeting up at just the right time. One late afternoon in the summer of 1972, I heard a performance of one of Hindemith's viola sonatas in a small church in New England. It immediately served to process a feature of my idiom, and this occasion sponsored vivid and intense feelings and ideas which lifted me into the next moments of my life. Shall we ever have the means to analyse that? Why that particular work?

When we have lived all there is of our lifetime, our families and friends will at some point look through and sort out what we call 'personal effects'. What an interesting way to describe what we leave behind. Effects. Articles of use? What I have caused to come into my existence as expressions of the very particular life I have lived? Why not borrow this ceremonial phrase and apply it to living? What are my personal effects? Where are they? As psychoanalysts we have, of course, to include the persons we affect and what we create in them of ourself and former others. Aside from this psychological establishment, we create a field of objects which serve to express our idiom and are its signature. Each of us establishes a private culture, and personal effects are those cultural objects we generate.

In health the true self continuously establishes its idiom and the fashioning of a life is the work of the destiny drive, as our urge to elaborate this idiom partly results in our creation of personal effects. As the psychoanalyst tills away, interpreting the roots of free association, identifying the branches of transference expression and reconstructing the family trees in a patient's life, he must find some way to catch glimpses of the forest. Does he have a point of view that enables him to see the analysand's culture? If he is useful as a multiple object, if his presence is the object of the patient's true self, then he will, in time, carry many of the patient's personal effects, and the destiny of the analysand will have been partly fulfilled: to establish a cultural life from the idiom of the true self.

Chapter 3

Off the wall

Countertransference theory serves an increasingly important function in the therapeutic community, as it allows the psychoanalyst to talk about his own emotional reality, mental processes, and self states as they exist in his work with patients. Freud led the way in *The Interpretation of Dreams* when he spoke about himself in what we refer to as his self analysis. Unfortunately, though, this very important part of the psychoanalytical situation – the self-analytical element – has been fixed as an historical figuration of Freud's. Occasional references have been made in the literature since Freud about the necessity for practising analysts to continue with a self analysis, but the analytic community has made comparatively little effort to evolve and use that voice that Freud established in his writings – a voice that speaks of the person's experience as both subject and object. There are some notable exceptions.

The psychoanalyst as subject

I am most familiar with the efforts of English psychoanalysts to represent themselves in the literature as a subject. Winnicott found a way to write about himself. Bion, inscrutable yet evocative, private yet publicly adept, rigorously innocent and shrewdly analytic, comes to mind as a most courageous leader in the evolution of the analyst as subject. Think of his remarkable work *A Memoir of the Future* (1975), a fantastic autobiography, impossible to believe and yet strangely true to psychic life. In *The Hands of the Living God* (1988), Marion Milner wrote about herself in a way which enables the reader to participate in her life with Susan. Certainly Theodore Reik (1956) found language for his own inner experiences, and Harold Searles (1965) has established a narrative voice which enables the reader to know him, not simply as the analyst–interpreter, but as a subject in the total field of analysis.

There is something of a collective simultaneity of commitment amongst psychoanalysts in many different parts of the world to include the analyst's frame of mind as a valued source of information and to write in such a way as to inform the reader of this private use. I refer especially to the writings of McDougall (1985), Symington (1983), Coltart (1986), Ehrenberg (1984), Stewart (1985),

Klauber (1981), Feiner (1979), Giovacchini (1979), Rosenfeld (1987), Joseph (1982), Pedder (1976), Limentani (1981), King (1978), and Little (1981).

Of course we all know how embarrassing and irritating it can be when a colleague, in the name of scientific self-scrutiny, or humanist self-knowledge, promotes a 'confessional voice' to bear his disclosure of mind, affect, and self in work with a patient. I know that we have all been in such a position, where we are compelled to listen to a clinician's intercourse with honesty, giving birth to a revelatory issue that none of us believes. Any of us can, under certain conditions, compel ourselves to disclose to our colleagues our inner state of mind in work with a patient. But in some situations this amounts to an abreactive abortion of psychic states, inspiring in the audience a kind of annoyance over the falseness of such a presentation. I did not know Winnicott, but I have heard from his many colleagues that to read him is like being with him. He is there in his prose. I attended Bion's seminars, and I know that reading his work is strikingly similar to being with him. And Marion Milner, who is possessed of a very rare gift indeed, represents her self in her writing.

When we objectify our self, either in that intermittent inner subvocal dialogue that is the opera of our internal world, or when we speak to the other about our self, we stand at some slight remove from this self that we are, and we address this object that is our self. Freud did this in his self analysis and my view is that such a procedure, of establishing a dialogue with one's self, is a feature of what we could term subject relations theory. Subject relations theory refers to the complex field of relations any one person has to himself (and from himself) as an individual. Finding a way to be a subject, in oral or written discourse, means finding a way to express one's inner status in the moment, unhindered by the knowledge that no such subjective state shall ever escape the problematics of unconscious context.

It is my view that the successful establishment of the analyst as a subject in the field of psychoanalysis, whether this is accomplished in prose, or, as I will discuss shortly, in clinical work with a patient, depends on the integrity of the analyst's relation to his own subjectivity. This evolution of the self-analytic element, into prose or interpretive work with patients, is a discipline that is achieved only by rigorous work. The patient or the reading public should be able to link the analyst's narrative of his subjectivity to the analyst's person. This compatibility of idioms (person and narrative) authorizes the value of the self-analytic element and differentiates it from a seduction. A disclosure of mental content, psychic process, emotional reality, or self state (whether in writings or in sessions) that is congruent with the person of the analyst is unlikely to be an artifice or a seduction. There must be integrity to the self-analytic process for it to be of use to us, either as patients or as analysts reading someone's writings. It is this discipline and integrity which, I think, lead us to celebrate the written works of persons such as Milner, Winnicott, Bion, and Searles, because we sense the authenticity of their use of self as an object in the analytic field.

Although I shall discuss the clinical uses of the analyst's experiences as subject in the analytical field shortly, my present intent is to address the function of the analyst's reports to his colleagues. (How can we develop a narrative that will account for our psychic presence in the analytical situation?) While it is important to know what interpretation an analyst gives to his patient, in the name of psychoanalysis, it is equally interesting to know what he has thought of saying, but withheld. In the course of any session that is reported, what wayward thoughts, fantasies, or images have crossed the analyst's mind? How does his imaginative conception of the patient change? This is slightly different from wondering what his object representations of the patient are, as an imaginative conception suggests an intersubjective process that heeds the laws of such mutual unconscious communication. As the patient narrates his life (let us say, the details of his previous day's encounters), how does the analyst imagine the patient as a participant in history? If a patient tells me about visiting a friend, of how this friend criticizes the patient for something, and of how the patient responded to this criticism, do I simply identify with the patient, experiencing the friend as critical? Or do I imagine the encounter differently? Do I identify with the friend and agree with his criticism of the patient? Do I accept the narrative at least as a process if not the content, reasonably at peace with simply listening, or does an objection occur to me, stopping me from simply listening, moving me to an interrogative position, or into an affective response to the narrative?

Off the wall

What are the origins of an interpretation? Some interpretations might be quite obvious to the patient and analyst (and to colleagues hearing it), but much of our work involves exploring issues that are not clear. What is the basis of a particular emphasis in our questions to a patient? Why do I select a detail from the narrative and exclude other factors? Why do I respond to a patient's request for a response and yet at other times remain silent? I can, of course, add many such questions, but I will have done my work if it is clear that I want to have greater access to the analyst's inner world in considering the practices of psychoanalysis and the theories that derive from these practices.

I must begin with a question – one that I have asked myself these last months. As I enjoy something of a sabbatical from intensive psychoanalytical work, reflecting on a now defined previous period of some ten years of psychoanalytic practice, I ask myself, 'Where were you?' No answer springs immediately to mind. Where have I been?

Superficially, I have lived a more or less ten-hour clinical day in a rather comfortable room which was part of my home in London. I could say that I have been living a particular kind of life in that room. Is it different from other rooms? I think it is. Unlike my living room, or my study, or any place where I spend a fair amount of time, the analytic space is somewhere between physical and

psychical reality. The room changes each day. It changes from hour to hour. It has a different feel from patient to patient. There are also periods in the day that give this room a certain definition. The house changes slightly and thus effects the analytic room. If the children are away at school, and I am absolutely assured there will be no noise, then I am more at rest than I am when they are either just going off to school or coming back. They tend to bang the front door shut in such a manner as to slightly shake the house. And, of course, every morning at 8.15 I tend to wait for the house to shake.

But the room has a curious way of coming to mind when I ask myself where I have been. I have been in that room, and it is a space somewhere between the physical and the psychic. But if I approach the question from a very different angle and remind myself that I was once something of an athlete, and at another time a university scholar, and if I recall running the 400 metres and remember teaching Shakespeare, then armed with these memories, how do I proceed to say what the act of psychoanalysis is? The mind boggles.

I remember escorting people into the consulting room. But after years of knowing the same person so intensively, I'm not sure it's accurate to say that it is quite the same thing anymore as escorting a person into the consulting room. I don't think the concept 'person' quite describes what that moment is like. I can recall escorting a particularly difficult woman into the room who was enmeshed in a negative transference. Inviting her into the room was more akin to opening the door to the furies. It amounted to a transportation of mental elements. Another patient who went through a very severe depression was so adept at conveying this mood that it felt as if I were physically lifting him into the room. Another patient always entered the room like an eager actor rushing on to the stage, the understudy's moment; I usually felt momentarily awkward until I sat down. I suppose I was then more comfortably situated in that position – as audience – that I was meant to occupy.

Sometimes I would sit down, in the classical place, simply pleased to be able to listen and concentrate. At other moments, I would sit down in order to be comforted by my chair, protected from the predictable battle that would ensue. I can recall a time when a patient, towards the end of her analysis and by then very much better, enabled me to sit in my chair for the fun of it. Regrettably there were times when I think I must have approached my position like someone heading toward the rack: fifty minutes of torture!

While sitting in my chair, out of the patient's view, I would look at different objects in my visual field and in different ways. Is it possible that the analyst's visual experience of his object world is unconsciously co-ordinate with the patient's discourse and transference usage of the analyst? If only we could find a way to discover the logical paradigms of patient–analyst interaction. I would often look at a nice long off-white wall opposite me. During the course of the day's journey the wall would register the light in subtle ways and this was enhanced by the fact that the surface was uneven, enabling it to have a mixed media potential.

I would gaze at the wall, often invited by the figurations of light, or I would look into it as a material eternity, with different patients over different periods of time for, I am sure, varying reasons. Although I have paintings, ceramics, oriental rugs, and other objects in my visual field, I feel confident that certain of my interpretations were, to coin a phrase, 'off the wall'.

I saw a schizophrenic woman in analysis. She spoke infrequently, and after a very long time working with her, when the fabric of coherent thought faded and I felt rather lost, I was aware that when I listened to her I always looked at the different patterns of light on the wall, or out the window at cloud formations, but I rarely 'travelled' about the room looking at the space's 'internal' objects. I believe, on reflection, that my visual orientations metaphorized my state of mind: I could not focus on this patient's internal objects, nor on the hard direct objects in the room. I expect that when I looked at the complex, visually articulate patterns on the rug this was a different psychological act from when I was lost in the wall. And sometimes I would look at my shoes, or my torso, or my hands. Why? Where was I? Well, when I looked at my watch, at least I could answer that question!

And where was I during those hundreds of hours listening to the patient talking to me or undergoing a particular articulation as the transference object? I am reminded of Paula Heimann's (1956) classic formulation of the transference. We must ask who is speaking, to whom, about what, and why at that moment. She emphasized that the object of the address, the content, and the motivation could change many times in any one session. The patient could begin as mother speaking to the analyst as an adolescent, then recall an adolescent regression to earlier child states and swiftly alter the speaking voice to that of a mother addressing a small child analyst, then move to being the small child addressing the analyst mother, who might subtly change into the father, eliciting in the analysand a different child voice. Later, Bion suggested that we could not simply conceptualize this process according to whole persons or even parts of whole persons, and that it would be more accurate to speak of elements of the mind addressing one another. But as I look back on my work to wonder where I was and to think about the origins of interpretation, I recall that extraordinary experience of not knowing what analysis was and yet of being the analyst. Although I did upbraid myself now and then for not knowing what an analyst was, I developed an increasing respect for this position and over time regarded it as an important, indeed essential, feature to being a psychoanalyst. Does this mean being someone who does not know his own being? To some extent I think it does, and certainly Bion (1970) has said as much. I believe I am addressing that mental frame of mind he described when talking about the analyst's responsibility to be without memory or desire; I also think this absence of knowing is perhaps true of that psychic state accomplished by evenly hovering attentiveness. After all, if we are evenly hovering ten hours a day for tens of thousands of hours in our analytic lifetime, it's fair enough to think that our sense of our being as an analyst will be rather odd.

The sources of interpretation

Where did my interpretations come from? I think I never knew. I do not mean that I never knew what I thought. Like all analysts, I had an idea of what I thought the patient meant, and I would put it to him for consideration. When making a reconstructive interpretation, I would take care to put the construction in simple and basic terms, and I did so believing that my formulation was correct. But that does not address the problem of the origins of an interpretation. I knew what I thought, but I did not know why I had that particular idea (and not several other plausible ones) at that moment. However, I have said that this not knowing is essential to analytic practice, which leads me to wonder if my interpretations came from that life the patient created for us. Each analysand uses us as object: we are guided, given shape. One moment we are moved into this person's adolescent position, later his infant state. Another moment we are being shaped into the father or aspects of the mother. Sometimes we are utilized for our mental functioning, and it's more pertinent to say we are used as a function of an element of psyche. No doubt some of my interpretations came from my interior mood, biasing me toward the selection of content and sponsoring a certain emphasis I gave to my comments. I am not saying that my interpretations are the final evolution of the patient's projective identifications, but I do think that my interpretations are inseparable from the patient's use of me in the transference. I do not believe there is such a thing as interpretive neutrality or a surgical stance that allows one a mood of emotional coldness, as Freud suggests. What I think of saying to this particular patient is inseparable from the fact that it is this patient to whom I deliver this comment. What I say may sound like other comments delivered to other patients, but it is not the same.

I am inclined to say something ridiculous in order to push myself further toward answering this question: Where do interpretations come from? Well, I shall begin with a sane answer. They come from our 'understanding' of the meaning implicit in the patient's discourse. Freud wrote of identifying nodal points. Or we can ask ourselves in what way the patient's speech metaphorizes the transference. Well, we have many models for organizing the analytical material, but I do not think such frames of reference process all that is conveyed.

For example, it came to my attention one day that while with a particular patient I was holding my breath. I was not breathing properly. I was tense and felt all bunched up inside. On further consideration I realized that much of my interpretive work had come from my bunched-up soma. If an instinct is a demand upon the mind for work, for psychical representation, the patient I was with used psychical representations to make a demand on my soma for unwork. And we can wonder where those interpretations, prior to this understanding, came from. I would have to say partly from a creature (myself) that was only just breathing and all bunched up. Hardly a good medium for interpreting.

I am sure, however, that many interpretations with certain patients originate from our soma. I may ache from psychic pain affecting soma, and my interpretation will come from there – the ache. Or a patient may be so overwhelming, my anxiety so high, that I am more a creature of my respiratory system, so that some interpretations will evolve out of this somatic distress. And of course, now and then we encounter a patient who inspires erotic wishes in us – they affect our soma – and interpretive work will emerge from the struggle with that somatic registration. It is well to bear in mind that often a patient's instinctual drives seek a route to mental representation through the analyst's soma, given that the patient trusts the reliable link between analyst's soma and psyche.

But I return to the wall. Some of my interpretations seem to have come from there. I can remember the occasions when I would gaze at a particular pattern of light on the wall, which I dwelt on while listening to the patient. The effort to form an interpretation seemed to emerge from a visual place. (How different this is from interpretations that seem to spring from the auditory, in response to the patient's phonemics.) Is it possible that in 'gathering' an interpretation off the wall, I am creating a comment out of the blankness of the screen, rather than linking up signifiers latent in the word presentations? Does the pattern of light serve as an area I can go to with this patient at this moment to serve as a potential space for my comment? Sometimes the shaded and blended play of light on the wall serves as a point of inspiration, rather than the literary critique of signifier–signified, or the objectification of deep subjectivity which is part of the effort to give voice to the countertransference. Is the mental origin of this interpretation significantly different from somatic, auditory, and hermeneutic processings of a patient's being, relating, and signifying?

I seem to be saying that analysts are mediums for the psychosomatic processing of the patient's psyche-soma. And that we 'find' different patients in different locations depending on how we are unconsciously invited to process them. I may be working with someone in my soma – in the stomach, the back, or in my respiratory system. I may be considering someone on the wall, in a cloud, or somewhere in the carpet. I may textualize a patient's discourse into a phonemic script, listening to the punctuation of the unconscious.

Interpretation, then, involves the analyst in a transformation of the patient's use of the analyst-medium, a countertransference into meaning and language. Where are we when we make an interpretation? Where have I been with different patients at different times? Of course, I do not think that the content of a comment necessarily has any reference to its origin, but I do suggest that we work from or with different phenomena in the mulling over of our life with the patient just prior to a comment. I may be listening to the patient but visually intent upon looking at patterns of light on the wall. Or I may be lost in memory of a previous session. Or I may be amidst an inner body state which seems to be the primary point of perspective. The point of view does not always determine the interpretation. It is an early feature of the interpretation's status as it metaphorizes the analyst's state of mind and self at that moment.

Indeed, in the analysis of severely disturbed patients I think all analysts who are free of reassuring constraints of a particular dogma of practice (i.e., an applied

psychoanalysis) have a recurring experience of no longer knowing what psychoanalysis is. Winnicott claims that he often made interpretations to inform the patients of the limits of his knowledge. But I am quite sure we make comments to hear the voice of reason amidst a most confusing situation. To some extent, we speak to the analysand to work through the unprocessed situation that confronts us. We work upon or within our self, aiming to transform our inner state, to place ourselves in a position to make an interpretation. Much of the therapeutic work of a psychoanalysis takes place entirely within the psychoanalyst as he processes his own inner turmoil, or useless ignorance, or ineffective remove, etc., in order to address the patient.

Some years ago a woman of twenty-two came to intensive therapy referred by her general practitioner. For the first three weeks she politely, and at times coyly, informed me of her life history. Then one day she came to her session, sat motionless in her chair, stared straight ahead, and said nothing. In the previous hour she had become tearful when discussing her father who had died suddenly several years before. I said that perhaps she had found remembering him sad and upsetting. She remained utterly and eerily silent. In fact she said nothing for the next ten months of her three times weekly therapy. For some time I endeavoured to hazard guesses about what was occurring to her. About a month after the onset of her silence she would occasionally rock back and forth in her chair. Then some weeks after that she gripped her left forearm with her right hand, placed between her legs, stooped over slightly, and moving her body back and forth, rocked her arm in an independent motion. Whenever I commented, she would immediately stop her rocking, stare at me intensely for a few seconds, then drop her head which would be enveloped by her very long hair. I shall not discuss those interpretations and inquiries I made. I did discuss the situation with colleagues, and I received a considerable range of views from ordinary hysteric to borderline, to catatonic schizophrenic. None of this helped me at all.

Interestingly enough, however, I did not feel greatly persecuted by this very long silence. I worked in a small under-used psychotherapy centre in central London. We had very few patients, and I really had nothing else to do with my time.

I also liked the looks of this woman. She was from the Far East and strangely beautiful. To be with her was an odd experience, but not distinctly unpleasant, and after a few months I would wander off wherever my mind would take me. Then on a lovely May day I said to her, speaking to myself out loud, 'You look like a young woman sitting on a park bench', and the patient laughed. It was from this point that she resumed talking, and after some years of psychotherapy embarked on a fruitful analysis with me.

Perhaps because I was so relieved by her resumption of speech, or perhaps because she also flooded me with information, I was not immediately aware of why I spoke and of why she replied. Where had my comment come from?

Every session this woman arrived in the very same brown paisley dress with black shoes. I didn't know whether she had additional clothes, but certainly this

was what she wore to therapy. I became quite accustomed to her 'habit', to its absolute regularity. Indeed, it seemed apt, almost helpful, to that curiously pleasing meditation that occurred between us. But on the day of my comment she wore a different outfit: a flowery skirt and a white blouse. Same shoes. And I did not notice this! At least not consciously. But if we think of this act as a cue to the therapist (this was before my analytic training), then my freedom to talk out loud was perhaps sponsored by her change of habit. Of course I have had many occasions to think about this period of her therapy/analysis, and one feature is striking: that she needed a long, benign, undirected thoughtfulness on my part. She needed me to find and use those internal resources within myself, before she would make use of me. (At a later stage the analysis was stormy and intense.)

Knowing and not knowing

But where does this leave us? Do I conclude that we really do not know why we say what we do at any given moment to a particular patient? Does this not suggest that we are profoundly lacking in any expertise? After all, how is this not knowing any different from any other person's not knowing in the patient's life? In the United States of America, where many people sue at the drop of a hat, psychoanalysts might live in dread of a patient bringing a court action on the basis that his psychoanalyst doesn't know what he is doing. After all, other mental health professionals, armed with their diagnostic manual – the DSM III – can practise with more certainty.

To me this not knowing is an accomplishment. I am certain that it has taken me years of experience as an analyst to value this frame of mind and to know it for what it is – a necessary condition for the creation of a potential space, an inner analytic screen that we sustain and which registers the patient's idiom. The patient's registration of idiom, an in-forming not only of an instinctual derivative, but the force of true self, and the scripts of self and other, can only be established through my not knowing. Interpretation does not emerge from the patient or from myself. As Freud said, it is a dialect(ic) of two unconscious systems, and each interpretive act acknowledges this movement of patient to analyst, of analyst to patient.

Of course each analysand learns a great deal about himself through the contents of interpretation, whether that is the elucidation of a constellation of memories that are de-repressed or whether it is an enhanced understanding of the nature of certain mental processes. I believe, however, that those analysands who have truly changed very deeply are the ones who have 'grasped' the analytic sensibility, who have found that freedom that emerges with a particular kind of not knowing that is essential to progressive registrations of the self and incremental intimacy with the other. It amounts to a kind of pleasure. A pleasure in the formation of potential space, as from this discipline – essential to the life of the subject – the person can entertain ideas and feelings that arrive with the integrity of conviction.

Of course there is an inevitable tension between the analyst's urge to know and the essentials of not knowing. I am certain that my most common error as an analyst occurs when, after working with a person for some time, I have organized the individual into a set of interpretive references, yielding up in each session, one or another of ten or fifteen by now fairly routine and predictable interpretations. However, there are moments in the course of an analysis where I think it is quite right that the analyst, in working through a particular interpretation with a patient, will have to repeat himself, with variation, many times. It is important to 'hold one's ground' as we say in England – a faint refrain from a colonial past. But I am not happy with myself or my colleagues when we praise ourselves too much for our refusal to give in, for our moral upholding of the analytic stance, for our trenchant determination to interpret in the transference and not give up. It is precisely this element in us psychoanalysts that Winnicott, Bion, and Lacan have turned away from. Each analyst who comes to know his patient through a coherent analytical understanding of the patient must unknow him.

This unknowing process, perhaps akin to the concept of unbinding (see Green, 1987), is essential to any further generative knowing, and to any further symbolically complex binding. Unknowing is essential to the creation and (internal) maintenance of the interior analytic screen. That which has been known after a while must be assumed to be still available to both patient and analyst as they rid themselves of such organization of the unconscious in order to receive new unconscious communications, made possible through unknowing. In my view, this establishes something of an essential dialectic, one that I think is at the heart of creativity in living, a dialectic between knowing (organizing, seeing, cohering) and unknowing (loosening, not perceiving). I believe that those analytic theoreticians who argue that the self is an invariant, and the knowing of the self is essential to an analysis, and those who take the opposing view that the self is an illusion, an entrapment of the subject in the fields of the imaginary, are both correct. The one is indispensable to the other. Were we simply to be impressed by the invariant core that we were and to split off the unconscious as an interesting but somewhat distant element, we would create an imbalance in the equations of the dialectic. If we take the view that the self is a somewhat feeble illusion concealing from us the ineffable inscrutability of the unconscious, then we err in another direction.

How do we make use of this dialectic? What does this have to do with that place where I have been as an analyst and with the origins of interpretation?

The dialectics of difference

To some extent, the above is a plea for a slightly different emphasis in the practice of analysis. We need to bring more of the analytic sensibility into our work with our patients. It is inconsistent with this sensibility for the clinician simply to interpret to the patient in whatever way (calmly, diligently, for example). However correct one feels at any moment with an analysand, it is inconsistent with the entire nature of the psychoanalytic accomplishment for the analyst only to tell the patient what the unconscious meaning of his communication is, whether it is to reconstruct the past or to interpret in the here and now transference. Because at any one moment, regardless of how certain we feel, of how passionately we hold a view, or of how correct we indeed are, such certainty is the function of our knowing, but the equally significant function of not knowing must be represented. For an interpretation that seems quite correct to us might, upon the provision of further associations provided by the patient, prove to be incomplete or absolutely incorrect. So how do we bring the receptive capability of unknowing, which I argue maintains the analytic screen, into the interpretive situation?

It can be accomplished in my view only if the analyst takes himself as a subject in the analytical field. The analyst must reveal more of the analytical procedure to the analysand. However valuable his conclusions culled into the secondary process as an interpretive content, this is less meaningful, in my view, than the processes leading up to such an interpretation. When a patient needs to know why I have arrived at a comment, I will say how I have composed my interpretation. I do not always ask what associations come to the patient's mind, nor do I take up the question as a transference act. Sometimes a patient will not ask how I have arrived at an interpretation, but I will say that I want to indicate how I came by it, and I will trace my footsteps. This is one of the important features in both authorizing and limiting the function of the subjective.

I also differ with myself. When I am unhappy with a comment, either because I can tell from the patient's associations that I am wrong, or because further internal work supplants and alters a previous comment, I will criticize myself. And sometimes I will say, 'You know, that's absolutely wrong, isn't it?' or 'No, I'm wrong!' When I differ with myself, I destroy a previously established particle of knowledge. I then create its opposite, a space that now contains not knowing, but recognizes the presence of an unthought knowledge that may find its way to knowing. In the first sessions of an analysis, when I think that the patient is correcting a misperception on my part, or struggling too hard to adapt to an error on my part, I preface a correction with, 'You disagree'. By endeavouring to introduce the factor of difference, we slowly establish the dialectics of difference. I want to be free to differ with my analysand. I want him to be free to differ with me. And it is my experience that the analyst can establish the ability to differ early on in an analysis, even with patients who are seemingly so narcissistic or borderline that one would have thought they could not bear an interpretation that they found irritating or wrong. But I think they can. And I think it can be accomplished in a series of steps.

First, the analyst establishes a relation to his own subjectivity. He becomes a subject in the field of analysis and thinks about what he has said (his associations, as it were) in a manner that is similar to the way he considers the patient's associations.

Second, he recognizes each moment that the patient disagrees with him and very carefully articulates the patient's corrections. If the patient seems hesitant after I deliver an interpretation, I will say, 'But something about what I have said

is not quite right'. If he mumbles in weak agreement, I will say 'I'm wrong' and analyse the patient's reluctance to correct me. And as we all know, more often than not, this will be accompanied by analysis of the analysand's discomfort over disagreeing.

Third, the analyst disagrees with the patient. To establish this as a non-traumatic and essential factor in analysis, the analyst should state it simply, in a relatively inconsequential moment, and as early as possible within the analysis: 'I find I have a different way of looking at what you have said, from your understanding of it'; 'You have said that the events you reported don't matter to you, but I disagree: they clearly do!". Such interventions are common and essential examples of what I mean by disagreeing with the patient.

By establishing difference as an important part of the analytical sensibility, first by differing with myself, second by affirming the patient's disagreements with me, and finally by disagreeing with the patient's comments, I am more able to be openly confronting of an individual than might otherwise be the case. In recent work with a paranoid schizophrenic who would become enraged with me in sessions, I would often say, 'Well we disagree, don't we? You think X and you may be right. I happen to think Y', and this dialectic was very important because I was analysing his manic defences which was only possible because the analysand was by then accustomed to the dialectics of difference in our work.

Establishing a dialectics of difference with a patient, particularly with those who are very disturbed, is crucial to the successful management of the patient's regressive use of the analyst in the transference. An analyst who has established this as one of the rights of interrelating does not by any means disqualify himself as a subjective object or a self object. It simply means that he is a subjective object with a working 'not me' element that allows for the intersubjective processing of confict. I am pleased that amidst intense transference regression, when a patient needs to be very ill in my presence, I can both sustain this patient's need and maintain my function as an interpreting analyst. Disagreement with a patient, undramatically delivered yet processing appropriate affects, may be crucial to the working through of a transference psychosis.

The dialectic of difference is in part an unbinding process that checks the binding work of interpretation and lessens the likelihood that interpretation itself could become a resistance to the free associative process. When a patient can consistently anticipate what his analyst will say to him on the basis of reported free associations, then in all probability the analyst's interpretations have become a resistance to the analytic process.

Free association is somewhere between knowing and unknowing, binding and unbinding. As words are used to speak one's mind, it is possible to consider this a form of knowing and a binding procedure. But as one is meant to say whatever comes to mind regardless of how silly or senseless it seems, this invokes a different principle: of unknowing and of unbinding. Perhaps the inspired thought, the deep reflection, the de-repression of a memory, emerges from an optimal state of tension between the binding and unbinding process. Elsewhere (Bollas, 1987)

I think of this as a tension between the conservative and the transformational processes, between the part of us that stores the experiences of life (in an unchanged state) and the part of us that transforms our experiences through symbolic representations.

The analyst's use of free association

When the psychoanalyst takes himself as an object of reflective consideration and analysis, he shares the patient's privileged position. This is not an indulgent and gratuitous sharing, but a discipline: a placing of one's self in a situation allowing for a rigorous analysis of the material. As this develops, the patient is, of course, in a position to reflectively consider and analyse the analyst's associations. This dialectic creates in the first place a field of signifiers that become lingual potential spaces for the evocation of repressed memories, or conserved self states, or for the arrival of new internal objects. But each accurate association adds to an increasing field of other accurate associations which taken together constitutes the construction of a processing medium, created from the psychical work of the analysis. If we think of Bion's theory of thinking – that it is the thought that creates the mental structure, and that structure derives from thinking – then the analyst's associations add to the mental structure being developed by the analysis.

I have little doubt that my use of the word 'association' as it comes from the analyst in the clinical hour will cause distress. What exactly do I mean? Am I suggesting that the analyst should say whatever comes to his mind without censorship? And if I am not saying this, then in what sense could his associations be truly 'free'?

As I think of it, the analyst's associations are musings. I muse on what a patient has said, or not said, or how the patient behaves. I say 'It occurs to me that . . .' and proceed to say what I have in mind. I need further elaboration, and I need the patient's assistance. As I put my musings into language, I release signifiers into a potential chain of significations. The patient is free to discard associations that he thinks are on the wrong track, to select those with which he agrees, or those that speak to him, and to choose meanings from my musings. We could say that this is a process of free negation or free destruction, leading to free choice, and ultimately to free association. All patients need to destroy the analyst's associations in order to create out of such ideas a compatible set of views which feels about right to him. He develops a sense of trust in the process of thinking and uses this eventually to his own advantage.

We are well aware that in the practice of psychoanalysis these days we rarely see the neurotic patient who can freely associate, whose feelings are evident in the hour, whose resistances to speaking an uncomfortable thought are apparent, and whose dedication to understanding himself is a vital part of that therapeutic alliance that allows him to overcome resistances and work through unconscious conflict. What I am focusing on in this chapter is less relevant to work with the neurotic patient, than to the schizoid, borderline, and narcissistic patient

– the individual who either cannot speak or who is so suspicious that he dare not; we need to place a different emphasis on the rules for the practice of psychoanalysis.

I think that the analyst needs to become a subject in the field of analysis, to make himself available for the patient in this way, and to establish a dialectics of difference: I think of this as part of an overall procedure of rendering psychic, of making psychic. By providing my associations to the patient's being or material, by musing on his presence, by remembering previous sessions, by posing certain questions, and seeking particular clarifications, I transform facts, or 'thing presentations', into psychic elements. Unreflected-upon elements such as the patient's mood, his manner, his statement of fact, even if it includes reporting a dream, are not psychic elements but something closer to what Bion (1962) means by beta factors: 'undigested facts'. The analytical process is a procedure for the making psychic which involves transforming facts into reflected objects, into mental objects, that in turn link up with other mental objects, to become part of intersecting chains of signification enriching a person's symbolic life, and also constructing a mental structure that can enhance the individual's mental processing of the facts of his existence.

Of course this view of the analyst's clinical orientation raises important matters of technique. How do we make our associations available to the analysand without it constituting an intrusion, or constituting a subtle takeover of the analysand's psychic life with the analyst's? Although I shall not take up these technical issues now, I will add that the analyst's reporting of his thoughts and associations must be momentary and set against the background of the patient's discourse and the silence that creates the analytic screen. A continuous, incessant flow of analyst's thoughts or observations would not be appropriate. The clinician must choose the right moment, select from and speak his associations in such a way as to create a set of mental objects that can be reflected upon by the analysand, in much the same way that both analyst and patient think of the dream. So, although there will be occasions when the analyst will elaborate associations, it is important for the analyst to stop in order to create a boundary around the association. In this way it is left as an object, to be considered by the patient, to be returned to after a period of hesitation, for potential usage. This principle of usage of oneself as a subject in the analytical field provides some overall guidance for the narrower technical issues.

Finally, it is my view that the process of rendering psychic, conceived of in the context of an object relationship that is characterized by a principle of dialectics of difference in which the analyst establishes himself as a subject in the field of analysis, constitutes a valid communication of what we can term the analytic sensibility. This sensibility is characterized by a paradox in our lives – that we are both subject and object. We provide the associations and then we reflect on them analytically. To be our own enigma is vital to our creativity. To be unknown to ourself is not necessarily a lack. We need unconsciousness in order to make a creative use of consciousness.

An analyst can establish himself as a subject without ever introducing into the analysis disclosures from his life or reflections on his own personality. To become a subject is not necessarily to talk about oneself to a patient, although in work with very disturbed adolescents or very psychotic patients it may be essential, in supporting their sense of belonging to the human race, to use examples from one's experience to say, 'Well, but that is human'. Otherwise, to be a subject refers to the analyst's psychical work on the patient's presence and narrative. Associating to a dream rather than interpreting it is a particularly valuable means of supporting the process of association. On hearing a patient's description of a fact in his life, I might say, 'That brings to my mind a dream you reported last month . . .'. I may say no more than this, identifying the dream, which leaves it up to the patient to associate, to utilize the psychic work, or to negate the analyst. Perhaps he will return to the analyst's associations later. If the patient refuses to be evoked by the analyst, or if he plays with the clinician's associations, either way the psychoanalyst has associated to facts, has transformed facts of life into psychical material, has linked past psychical material to the present, and has supported the rightful function of unconscious work.

While a dream serves as a particularly unique potential space for the evocation, establishment, and working through of the patient's internal world, I also take a patient's description of events and render them psychic if they bring other reported events to my mind. I also comment on the patient's presence and manner of being in a session. 'You seem perplexed', 'You seem tired', You look happy!' are remarks I make to sponsor reflection. But with a particularly difficult patient, who might demand my accounting for this comment, I may become the primary subject in the session as I associate to my impressions. The patient may seek to analyse me, perhaps in a triumphantly paranoid way, and if so, I will listen carefully to his angry comments and agree with him where appropriate, thus validating his estranged right to disagree, to have his own views. Some patients need to explore the analyst's way of knowing before they can commit themselves to a self discovery, so my 'analysis' or 'our analyses' of how I may come to feel the way I do, or think what I do, can fulfil an essential need in such a person to be seen and reflected by a good and sane container.

The object that is the source of the analyst's reflections, that establishes a limited but distinct view of the analyst as subject, is the patient. The analyst redirects himself to reporting associations, memories from and about the analysis, and senses of something – all within the context of the patient's presence.

The rights of idiom

Perhaps it is clear that I am linking the countertransference and the use of the self-analytic element in the establishment of the analyst as a subject with the concept of a dialectics of difference. I argue that this constitutes a particular relation to subjectivity, in which the analyst uses the fact of subjective idiom to his and his patient's psychoanalytic advantage. It is a way of acknowledging that personal

idiom always mediates the unconscious and its laws. Psychoanalysts make interpretations, they invent meaning; they do not discover the meaning conveyed by the patient. No two analysts would ever say the same thing to the same patient.

By establishing difference (with himself as well as the patient) as a crucial factor in the analytic work, the analyst enables himself to introduce a differentiated intellectual affectivity in the sessions. This is crucial to our comments to patients, our long struggles, and to our celebration of the analysand when our 'Of course!' emphasizes some aspect of the life instincts.

Sometimes we have no choice but to be bewildering. A person whom I have termed a normotic (Bollas, 1987) – an individual who is abnormally normal and who aims to de-subjectify the self in order to become a thing-object – needs to experience the pleasures of entertaining the subjective which I think has to come from the analyst. I am sure we can all think of cases where the analyst comes up against a patient who for one reason or other is bereft of signs of life, and the analyst's speech and affect are the life of the hour. Being strange to such a person, through one's comments, evokes his interest and brings to the analytic situation a certain imaginative freedom.

Some patients need me to establish the right of idiom, which I represent, not only through the content of my remarks but through my relation to subjectivity itself. One might object to this principle, not only on the grounds that it seems to violate analytic neutrality, but because it appears to place some mystical value on the irrational, giving the analyst an omnipotence that would be an abuse of the patient's transference. Is this not a call for whimsy, fancy, mysticism, isolated subjectivism; a call for any instinct to find its gratification through analytic acting out?

I believe all the above is possible. Were an analyst to establish as an ongoing act only the statements from association, or to indulge himself in the private pleasure of an odd remark, conveyed simply to put the patient in a difficult position, then, of course, this is abusive. Of course, so called 'ordinary analytic interpretation' is capable of the same valence, and perhaps it is even more disturbing because it might be delivered by an analyst as the truth, to be accepted by the patient, or worked through, where 'worked' could be read as in a psychic assault. The analyst who chooses to establish himself incrementally as a subject in his clinical work must, of course, come by the discipline needed to introduce this factor without it usurping the analysand's psychic uses of the analytic process and the transference object. Thus a sense of judgement and tact is essential here, as it is in any other analytic practice. I find that I am more mentally concentrated and thoughtful when representing the subjective (of content or personal idiom) than when I work in more classical ways. I believe my commitment to my own discipline, to my own manner of practice, is conveyed to the patient, and, as long as I carefully analyse the patient's response to my 'presence', and correct myself when I am wrong, I think the chance of error on the side of increasing analytic omnipotence or acting out is minimized.

The analyst must decide the appropriateness of providing his associations to the analysand's material. It should never usurp the patient's free association, even if the patient seems 'stuck' or is silent for long periods of time. Indeed, it should serve to facilitate the free movement of ideas, feelings, recollections, and self states in the analysand. In a way the analyst's associations may be the missing link in the patient's chain of associations, which is consistent with one view of projective identification: that the analyst carries split off ideas projected into him by the patient. I do not know if this is true of all associations carried by an analyst while with the analysand. Ordinarily I do not think the analyst should declare an association as patient-inspired; instead he should be an imaginative partner to the analysand, who will appreciate the analyst's effort of intelligence as the work of an independent mind involved in that complex interrelating that is psychoanalysis.

By establishing a working dialectic with the patient, one which cultivates rhetorical positions that affirm the difference between any two human subjectivities, the analyst sustains the intermediate nature of interpretation, as it can only be a comment 'placed' between patient and analysand. The analyst's interpretation of the patient's discourse, being, or relating is always hazardous, as is any effort undertaken by one person to claim knowledge about the mental contents of any other person. But this peril is no different from our 'collection' of interpretations, as its ultimate source must never be certain to us. To some this is a less than satisfactory account of the discipline of analytic interpretation, which, it is argued, is capable of exactitude. For me, however, any interpretation is always only partly true, as the narrowing of focus essential to the organization of comment about another person inevitably means that all other possible comments are at that moment unspoken. And the interpretation of that moment will be altered, perhaps completely abandoned, with the provision of further material during the course of analytic time.

By associating to an analysand's comments I aim to reveal more of the nature of those processes within myself that eventually go into the making of an interpretation. I intend the patient to participate in the evolution of my own thinking on the way to knowing. And vital to this endeavour, it seems to me, is the establishment of the right to disagree, so that neither analysand nor analyst is foreclosed by a policy of adaptation.

I do not know the sources of interpretation. I do not know why one day with patient A I find myself concentrating on A's word presentations, whilst the next day I might be mulling over his creation within me of some object in his past. Nor do I understand why one day with A I wander off, barely listening to what he is saying, yet on another day find myself acutely attentive to his silence. Some analysts might argue that each of my states of mind (and hence the origins of interpretation) is the work of a patient's projective identification. But this stretches a meaningful concept to an absurd extreme, to the point of turning the patient–analyst relation into a kind of seance, where the analyst is a spiritualist who lives out the lives of others: dead or alive. I am certain that each of my

experiences with an analysand is determined in part by their particular idiom, but I am equally convinced that my own unconscious processes are active in the genre of interpretive choice: whether I comment on words, object relations, moods, or the patient's self-experiencing.

I believe that all patients do sense the particular way his or her analyst organizes 'the material'. They also correctly perceive aspects of the analyst's personality. By establishing himself as a subject in the analysis, I think the psychoanalyst simply gives a more honest and analytically fruitful place to the subjective origins of personality, unconscious organization, and analytic practice. A patient might wish me to be an all knowing idealized figure, and certain transference needs are so intense that this is how I am constructed, but by being different, by establishing more openly how I think what I do, a patient is free to *think me* as an object. As I correct myself, as the patient corrects me, as I challenge the patient, as he challenges me, I have found what to me is a more trustworthy analytic mutuality in sessions. I believe that what I describe is a form of play in the analytic situation. Clearly I work this way because I am more comfortable with it and because I believe in it. I disagree both with those analysts who systematically and rigorously translate the patient's discourse into transference interpretations (all in the name of pure analysis) and with those who believe that each patient needs constant affective and interpretive adjustment from the analyst in order to feel understood. The first practice erodes the analysand's self-analytic capability and distorts the unconsciousness of the unconscious, leading to a secondary process over mentalization of psychic life, as virtually any discourse can be immediately translated into a transference response. The second practice expels the analytic element from the scenes of the analytic situation, as the clinician seeks positions of identification with the analysand to provide an empathically attuned response.

But each of these perspectives – the analyst as subject, as translator of discourse into transference, as empathizer, or as a minimalist auditor of the murmurings of the other – is important if understood as one element in the total field of analytic practice. We should find a way to integrate the many elements of these differing emphases in order to create our own practice. There is no such thing as *the* practice of psychoanalysis. For better and for worse, there is only each analyst's attempts, a fact of our daily lives that hopefully keeps us interested in whatever any other analyst currently favours as a new dimension in theory and practice, whilst inevitably sustaining in us a reticence to convert our analytic ideology into the analysand's fate.

The psychoanalyst's celebration of the analysand

If one of the aims of a psychoanalysis is to analyse as much as is humanly possible of what the analysand presents, and if we are not to be deterred by conventional social niceties in the pursuit of speaking the truth, then no particular feature of a person should be subject to an exclusion clause.

This ethic has often been a rallying cry to analysts who take it as an almost specially appointed task to analyse the patient's destructive mental processes. One of the facets of this emphasis is the technical difficulty of causing distress to a patient's narcissistic self valuation by focusing on disavowed destructiveness. I believe that this emphasis in psychoanalysis is indeed quite valuable, but I am puzzled by the fact that in the psychoanalytic literature, the rigorous analysis of destructive processes and the negative transference are presented as if this were a particularly onerous task. My experience is that most analysands are consciously troubled by their destructive thoughts, feelings, and actions, and though they do, of course, resist analysis of such factors of the personality in the here and now transference, they nonetheless issue the analyst with an implied licence to pursue his course of analysing the complex mental processing of hate. My puzzlement turns to something else – I suppose to this writing of it – as I try to grapple with what I consider to be a worrying exclusion, at least in the literature of psychoanalysis, of a more analytically difficult task – the psychoanalysis of the patient's life instincts: his love of the analyst, his creative integrations in analytic work, his admirable accomplishments in life (and analysis).

I find that some analysts are often too willing to head for analysis of the negative transference, ostensibly because this is where the rough work is, but in fact because they often feel on surer ground if they are analysing hate. Do we need to oppose the patient? If not, then perhaps in clinical presentations we need to advertise to our colleagues just how clever we are, and this often means demonstrating how we deconstructed the manifest text of the patient's material, or unflinchingly analysed the patient's unconscious negative transference. When we are in such a mood – and I suppose some analysts may practise within this mood their entire career – a patient's affection for the analyst, inspiring a particularly glowing account of the analyst, will only be interpreted as a defensive idealization of the analyst: and the split-off hate is pursued. I expect such a view is partly