The Use of the Self Revisited

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About the Author

Theodore J. Jacobs, MD is Clinical Professor of Psychiatry at the Albert Einstein College of Medicine and a training and supervising analyst at the New York Psychoanalytic Institute and at the Psychoanalytic Institute at New York University. He is author of *The Use of Self: Countertransference and Communication in the Analytic Situation* (1991) and is on the Editorial Board of *Psychoanalytic Quarterly*.

The use of the self revisited

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My aim in this chapter is to update, revise, and expand upon ideas concerning the analyst's use of self that I articulated in my 1991 book, *The Use of the Self: Countertransference and Communication in the Analytic Situation*.

My focus in that book was primarily on the phenomenon of

countertransference and especially on the way in which covert, unrecognized and unacknowledged, communications from the analyst can influence the analytic process. As I tried to demonstrate then, such countertransference reactions most often arose in response to subtle communications from the patient of which the analyst was unaware. Thus much of my book was devoted to elucidating the effect on the analytic process of the manifold unconscious communications between patient and

analyst that flow beneath the surface of the analytic dialogue.

The impetus to writing the book came largely from my struggle with my own countertransference feelings. In my training, countertransference was not something one talked about. Following Freud's view of countertransference as an obstacle to be overcome and Annie Reich's papers (1951, 1960, 1966) that reinforced the idea that countertransference constituted an interference in the analyst's ability to understand and to

respond effectively to his patient, classical institutes in the nineteen-sixties regarded countertransference as a problem to be dealt with privately by each analyst either in his own analysis or by means of self-analytic efforts. A certain shame hung over the whole notion of countertransference. One was supposed to have as little of it as possible and what one did have, was not to be publicly acknowledged. As a consequence of this attitude, there was little teaching about countertransference. It was almost never mentioned in case conferences

and students were wary about revealing it in their supervisory sessions. And when in supervision an intrepid soul did acknowledge a countertransference response, rarely was its relation to the patient's material or its impact on the analytic process explored. Rather, the candidate was told that she should take up this matter with her analyst. Clearly the implication was that countertransference represented the outcropping of an unresolved personal conflict that required more analysis.

The attitude toward countertransference had both historical and contemporary roots. Although Freud recognized the phenomenon of unconscious communication between patient and analyst as an important feature of the analytic process, he did not apply this insight to countertransference experiences. Thus he did not recognize that countertransference could be understood in part as representing projected and displaced communications from the patient that register in the mind of the analyst.

Instead, as I have noted, he viewed countertransference as an obstacle to analytic work that needed to be overcome, primarily through one's self-analytic efforts. In fact, in a strongly worded statement, Freud (1910) declared that no analysis could proceed beyond the limitations imposed by the analyst's countertransferences.

Freud's negative view of countertransference, which essentially halted effective exploration and use of countertransference experiences, for

some forty years, derived not only from his personal experiences in analyzing—he was well aware of his own tendency to be drawn into the transference—but from his concern that certain colleagues, Ferenczi, Steckel, Jones and others, were acting on their countertransference feelings in ways that were potentially destructive to the young analytic movement. It was necessary, Freud thought, to take a strong stand not only against such acting out, but against the dangers inherent in countertransference itself.

It remained for Heimann (1950) in England, to articulate a different and novel perspective on countertransference. Influenced by Klein's emphasis on the importance in infancy, and throughout life, of the defensive mechanisms of projection and especially of projective identification, she viewed countertransference as a creation of the patient's. The analyst's subjective experiences, in other words, could be understood as emanating via projective identification, from the inner world of the patient. Unable to cope with the

affects aroused by the warring internal objects that constituted the essence of her conflict, the patient projected aspects of that inner world onto, or into, the analyst. Thus by focusing on his or her subjective reactions while analyzing, the analyst had a window on, if not a pipeline to, the unconscious of the patient.

This essentially Kleinian view met with strong opposition in the USA. Although arising in part as a consequence of Freudian analysts' rejection of Klein's ideas concerning

infant development, and their strong championing of Anna Freud in the historic Freud-Klein debates of the nineteen-fifties, this opposition was also based on substantial clinical experience. Drawing on her many years analyzing candidates, Annie Reich, who was the chief American spokesperson for the Freudian view of countertransference, amply demonstrated the troublesome effects of countertransference in both its acute and chronic forms. So persuasive, in fact, were her arguments that for the next quarter century in the USA it was

the Reich-Freud view of countertransference, and quite exclusively that view, that dominated theory and practice.

It was not until the early nineteen-eighties that things began to change. At that time, several classically trained Americans, notably Gill (1982), McLaughlin (1988), Poland (1986), Chused (1987) and Jacobs (1986), began publishing articles that described not only the manifold ways that countertransference could manifest itself in the analytic situation,

but its effective use as an important element in technique. Some years before that, Searles (1959) and others in the relational school had demonstrated the power of countertransference not only to impede but to advance the analytic process; but it was not until more traditionally trained analysts began writing and speaking in a similar vein that a revision in thinking about the roles of countertransference and the analyst's subjectivity took hold in the USA.

The change was due to a number of factors. In American institutes, the influence of the European emigre analysts, fiercely loyal to, and defensive of, Freud, was beginning to wane, objectivity and positivism in the allied fields of literature, history and philosophy were under attack and were being replaced by a relativistic point of view, the British object relations perspective had become more widely known and appreciated, and Kohut's (1971, 1977) writings on self-psychology focused attention on the profound effect that failures of

empathy—essentially enacted countertransference responses—could have on the patient's sense of self and the ensuing analytic material. In addition, there was greater appreciation of the dyadic aspect of analytic work, a perspective stimulated by the infant research of Stern (1985) and others—research that supported the idea that, from birth on, human experience is profoundly affected by interpersonal as well as intrapsychic influence. All of these factors coming together in the late nineteen-seventies and -eighties contributed to the newer

perspectives on countertransference and process, the subjectivity of the analyst that were rapidly developing.

My own work as an analyst was markedly at variance with what I heard at our institute. There, even in advanced clinical seminars, countertransference was very rarely mentioned. The focus, quite exclusively, was on patient's material. And while the understanding of that material frequently seemed accurate and the presenting analyst's interpretation insightful, oftentimes the

patient did not progress in the way that one might expect. What seemed to be missing was the effect on the analytic process of the analyst's subjective experiences and the covert communications between patient and analyst that were taking place beneath the surface of the manifest exchanges.

I had found that my countertransference responses, conveyed both verbally and in non-verbal behavior, affected the analytic process, including the emerging material, in ways that were equal to,

and often outweighed, the insights gained through interpretation.

In an effort to make sense of what I was experiencing and the impact of my subjective experiences on the analytic process, in the early nineteen-seventies I began to take notes on this dimension of my analytic work. Eventually I published a series of papers (Jacobs 1973, 1980, 1986) on countertransference and related issues which, when collected in a single volume (Jacobs 1991), formed the core of my subsequent book.

This publication was not greeted favorably at my institute. The older, more traditional, analysts regarded the kind of open discussion of countertransference issues that I described in my book as inappropriate and in violation of an unspoken taboo. Consequently I was viewed as suffering from an exhibitionistic/masochistic problem that required further analysis.

Elsewhere, however, my approach found a receptive audience. A good many colleagues, it seemed, had been

waiting for someone to take the lead in opening a discussion of key elements of analyses that heretofore had been kept under a veil of secrecy. Spurred by the writing of the colleagues I have mentioned, as well as my contributions, in the last two decades, there has appeared in America a virtual flood of publications dealing not only with countertransference, but with the closely related issues of enactments, neutrality, abstinence, self-disclosure, co-created experience, and the unconsciously shared assumptions between analyst and patient that have

been designated the analytic third (Ogden 1994). Stimulated by many of these innovative and creative papers, by the important findings of infant researchers, and by increased clinical experience, I have sought to expand as well as to revise some of the ideas concerning countertransference, nonverbal communications, enactments and the question of self-disclosure that I discussed in my 1991 book.

In what follows I will touch on several of these issues without

attempting to include them all. The first issue that I wish to discuss is the question of non-verbal communication in the analytic process.

Although given impetus by the contributions of McLaughlin (1987, 1992), Pally (2001), and other colleagues who have enlarged our understanding of the significant role that non-verbal communication plays in every analysis, the study of non-verbal behavior and its relation to the verbal exchanges of patient and analyst remains a frontier that has yet

to be fully explored. In my own work I have been impressed by the way that close attention to the facial expression and bodily movements of patient both in the waiting room and as they enter and leave my office has opened pathways to the exploration of centrally important ideas and fantasies that had not been verbalized in sessions, either because they were not conscious or because there was a strong resistance to their verbal expression.

Such was the case with Mr N, a bright and able young man who sought treatment because at age 25 he had not been able to choose a vocation nor develop an intimate relationship. It was clear that he was floundering in life and that he had little purpose or direction. Until he was 17 years old, Mr N was viewed as an exceptional young person. Handsome and talented, he was an outstanding student and an extraordinarily gifted musician. In addition, he was an outgoing, friendly and thoughtful individual who was instantly liked by all who met him. A

rising star in his community, Mr N was expected—and expected himself—to achieve great things in life. Then when Mr N was a few months past his seventeenth birthday, his father, a distinguished and accomplished man in his own right, suddenly developed a progressive neurological disease. Within a year, Mr N's father was incapacitated. Placed in a nursing home, this once powerful man was reduced to being a helpless child who was unable to care for himself. He died within two years of contracting this debilitating disease.

The effect on Mr N was dramatic. Crushed by losing the father whom he relied on for support, guidance and encouragement—and with whom, unconsciously, he was in fierce competition—Mr N fell apart. He could not concentrate on his studies, became morose and increasingly isolated, and lost interest in his friends. Increasingly he clung to his mother who soon became his chief companion. Some brief therapy and a trial of medication effected little change. Although he was admitted to a prestigious college, Mr N had little

interest in his course work, or really in anything else. He became a desultory student, drank a good deal, took drugs, and eventually left school in his sophomore year.

For the next couple of years, Mr N alternately traveled abroad and spent time at home, but seemed to have no purpose in life. He had only a few old friends, and had no sustained relationship with a woman. On occasion Mr N would begin a relationship with a new person, but within a matter of weeks it would end,

and usually because Mr N found some reason to break it off. Clearly he was afraid of intimacy and of being attached to someone who might disappoint him. He found it safer to remain emotionally tied to his mother, a relationship that for her own reasons, she encouraged. Mother and son, then, clung to one another, each using the other as a substitute for the man that both had lost.

Given Mr N's history and current situation, I became convinced that to make progress he required an in-depth

approach, one that would uncover the roots of the profound regression into which he had fallen and that would help him work through the loss that precipitated it. Accordingly, I recommended that he begin an analysis, a suggestion that he readily accepted. For a period of almost eighteen months, the treatment went very well. Mr N took easily to analysis, associated quite freely, brought in dreams, and early on developed a positive dependent transference that in essential ways

reproduced the relationship that for many years he had with his father.

Then, a year and a half into the analysis, everything changed. Instead of communicating openly in sessions, with his thoughts readily shifting between past and present and ranging freely over a variety of topics, now Mr N focused repeatedly, obsessively, on a single issue: his relationship with C, a new woman in his life. In session after session, Mr N described every facet, every nuance of their relationship. While, initially, I thought this material

to be an important expression of Mr N's efforts to master an anxiety-producing situation—C was the first woman with whom he had been able to establish an on-going relationship—in time I realized that his preoccupation with this single matter, important as it was, was also serving a defensive purpose. By focusing so persistently on this one issue, Mr N was screening out other problems, ones that, unconsciously he associated with unmanageable anxiety.

What these other issues might be, however, I had no idea. I strongly suspected that something had happened in our relationship—Mr N now scrupulously avoided any references to me—that had frightened him and had caused him to retreat, but it was not at all clear to me what might have evoked such a response. I decided to wait and to see if I could pick up something in Mr N's associations that would help us both understand the source of what appeared to be a rapidly developing impasse. That understanding came

from another, quite unexpected, source.

It so happened that at that time I was seeing Mr N in my home office. Since he had an early morning appointment and I did not want to wake my wife when I got up, I often dressed in semi-darkness. This I could usually do without difficulty, but one morning, being short on time, I dressed hurriedly and went quickly to the office. As I greeted him, Mr N looked at me quizzically, but said nothing. At the end of the hour, as he

rose from the couch, he again looked at me in what I thought was a puzzled way. Then, without another word, he departed.

After that session I went into the house for a cup of coffee and, seeing me enter the kitchen, my wife burst into laughter. ‘Are you conducting an experiment in subliminal perception this morning?’ she inquired. ‘If not, I suggest that you change your jacket to one that matches your trousers. Otherwise you are going to have to deal with a bunch of very confused

patients.' What happened was this. Dressing in semi-darkness, I took from my closet the trousers belonging to one suit and the jacket from another, similar in color, but differently patterned. Encountering me that morning, Mr N was startled to see me wearing a clearly mismatched outfit, and also that I seemed unaware of the error. This sight terrified Mr N as it evoked memories of his neurologically damaged father and led him to worry as to whether I, too, was showing signs of organic impairment.

Actually this was not a new concern. For several months, Mr N had noted that I seemed to be distracted and forgetful and he had the idea that I was showing signs of deterioration. This idea so frightened him that he avoided mentioning it in sessions for fear of discovering that it was true. In fact, Mr N was not wrong in what he had observed. For a number of months I had been making a series of mistakes. I misplaced some bills, made errors in others, nearly forgot one appointment, and generally was acting in a distracted, if not confused,

manner. While I was aware of these mistakes, I rationalized them as being due to overwork, fatigue, and concern about one of my children who had health problems. What I realized only later, when I reflected on my behavior, was that it had developed after my father suddenly suffered a stroke. Ordinarily an exceptionally well-dressed and well-groomed man, after this cerebral accident my father dressed indifferently. Now he often wore mismatched and ill-fitting clothes, with the result that he appeared unkempt and slovenly.

Cognitively damaged, he had difficulty reading and remembering what he read. His short-term memory was impaired as was his judgment and thinking.

In an effort to cope with this loss and the complex feelings it evoked in me, unconsciously I identified with my impaired father. Like him, I made numerous errors, became distracted, and forgetful, and, in choosing a mismatched outfit, began to look like him. All of this so frightened Mr N— he imagined that history was repeating

itself and that I, like his father, was going to disappear on him—that he became paralyzed. Unable to speak of his fears, all he could do was avoid them.

Following the mismatched suit incident, I waited to see if Mr N would bring up this troubling experience in subsequent sessions. He did not. Instead Mr N avoided the issue and concentrated once more on his relationship with the girlfriend. One day as I approached the waiting room to fetch Mr N, I noticed that he was

looking at me in what I thought was an intense, piercing way. It was the same kind of intense look that he had given me when I appeared oddly attired for his session. Now on the couch, Mr N made no reference to the waiting room incident but carried on as before with a description of the latest incident with C, the girlfriend.

When during a moment of silence an opportunity arose, I asked Mr N about the waiting room incident. I described what I had observed and asked Mr N if he was aware of the way

that he had looked at me. I asked him, too, if he was aware of any feelings toward me that might have prompted what seemed to be intense curiosity. For a period of a minute or so, Mr N remained silent. Then, finally, he spoke. 'Is there anything wrong with you,' he wanted to know. 'Or do you always buy your clothes at a Salvation Army store?' For several months, Mr N revealed, he had been watching me make one error after another. He had been unable to bring up the matter, but he was pretty sure that something was very wrong with me. He wanted to

know if I was sick and, if so, whether I would be ending his treatment.

In response, I confirmed the accuracy of Mr N's observations and told him that a personal matter had been preoccupying me and had caused me to become distracted and to make the kind of mistakes that he had noticed. I also interpreted the connection that he had made between his father's illness and my behavior and explored with him the complex feelings that were aroused by his observing the difficulties that I was

having. For the first time, Mr N realized that he felt some satisfaction in seeing me, the doctor, the superior one, have problems of my own. This insight led to others and Mr N came in touch with the rivalrous and resentful feelings that he harbored toward me and his father. And in time he understood and could work through the profound feelings of guilt—and need for punishment—that he experienced for harboring hostile wishes toward both of us.

Thus in this case it took the understanding of enactments—non-verbal behaviors, on the part of both patient and analyst—for an impasse that could have destroyed the treatment to be resolved. This is often the case with enactments which in many instances represent complex interactions between patient and analyst that are conveyed in non-verbal form. And as was true in this situation, the analyst needs to observe not only clues contained in the patient's postures, gestures, movements and facial expressions, but

his own bodily responses as well, for it often happens that the key to understanding what is transpiring at a given moment in analysis lies not in the words spoken by patient and analyst, but in their non-verbal behavior.

Sometimes it happens that a communication of great importance is conveyed not in an action taking place in the analytic hour, but by means of the patient's dress and physical appearance. This was true of Ms Y, a young woman who sought analysis

through our institute and who was assigned to me as her analyst. A poet and musician, Ms Y placed little emphasis on clothes and regularly appeared for her sessions dressed in a wrinkled blouse and torn jeans. There was, however, some notable exception to this mode of dress. On Thursdays, I noted, my patient either wore a skirt and tailored blouse or an attractive and fashionable dress.

I thought, at first, that this change in her appearance was due to some professional activity of Ms Y's—she

gave music lessons and held a part-time job—that required her to look more professional. This, however, turned out not to be the case. The change was due to a quite different, and unexpected source, one that it took us many months to uncover. It was not, in fact, until material concerning Ms Y's applications to the Treatment Center spontaneously arose in the course of an hour that I began to understand her behavior. It turned out that in the course of the interviews that she had in connection with her application for treatment, Ms Y met

the director of the clinic. She immediately liked this kindly man who reminded her of her beloved grandfather. The loss of this grandparent when she was 6 years old was a severe blow to the child and for many years, she had unconsciously been seeking his replacement.

During the interview with the director, Dr G, he was suddenly called away by an important phone call. During his absence, Ms Y could not control her desire to know what Dr G thought of her and, yielding to

temptation, she glanced at the notes that he had jotted down as they spoke. What she read in his notebook delighted Ms Y. In his description of her, Dr G had observed that she was an attractive, articulate young woman who appeared for her interview fashionably dressed in a matching skirt and blouse. Ms Y was pleased by this description, just as she had been pleased when, dressed up to meet her grandfather on Sundays, he always complimented her on her outfit.

Ms Y very much wanted Dr G to be her analyst and was keenly disappointed when she learned that his role was limited to being one of her interviewers. Through certain misinformation that she had obtained from a friend who was being treated through the clinic, Ms Y came to believe that Dr G was to be my supervisor. Moreover, she figured out that Thursday was the day that I had supervision and through me she sought to make a good impression on Dr G. Thus, believing that I would be talking to him about her and describing her

appearance as well as the content of the hour, Ms Y made every effort to look attractive on Thursdays.

It was on that day, too that Ms Y often brought in dream or fantasy material. And so with my patient's mode of dress, it took some time for me to become aware that the content of the Thursday session was different and more 'analytic' than on other days. Here, too, by giving me interesting material that I would then report to Dr G, Ms Y was trying to impress the grandfather figure who evoked so

many fond memories and whom she so sorely missed.

Interestingly, at that time I did have supervision on Thursdays, although not with Dr G. How it happened that Ms Y detected that Thursday was my day for supervision is in itself a most interesting question. No doubt I communicated something to her on that day that was different from other days. Reflecting on this question, I concluded that the quality of my listening in the Thursday session was different from other hours. I

recognized that I was more alert, tracked her associations more closely and in preparation for supervision, no doubt jotted down more notes than usual. Although these clues were subtle ones and not easily perceived by a patient lying on the couch, clearly Ms Y had picked them up and had responded to them with changes of her own. And it was through understanding the changes that Ms Y enacted in the Thursday sessions that ultimately we were able to reconstruct an aspect of Ms Y's childhood that had had an enduring influence on her

personality development, her fantasy life, and her later object choices.

From the examples that I have cited thus far, it is evident, I believe that non-verbal behavior, and the enactments so closely related to it, regularly occur on both sides of the couch and form a kind of mini-drama within the analysis that often is the vehicle for the playing out of conflicts and fantasies that are of the greatest importance in the patient's psychology.

Since most often there is a mutuality to these enactments, the

question arises as to how the analyst should deal with his or her side of the equation. Should she simply confine herself to observing her own behavior, seek to understand its relation to the patient's material, and attempt to use that understanding to frame an interpretation? Or should she share with the patient some of her subjective experiences? If so, what would be the purpose of such a revelation? What gain would the analyst hope to achieve by employing it?

This is not an easy question to answer. In fact, it is one that currently is the focus of much discussion and debate. And as one might expect, there are no clear answers to this conundrum. Each situation must be dealt with individually, recognizing that self-disclosure of any kind by the analyst has a powerful and often enduring impact on the patient. In what follows I will briefly outline three situations in which I chose to disclose to a patient aspects of my countertransference that were enacted in sessions. I will try to explain why I

did so, and what effects these disclosures had on the patient. As will be evident, at times self-disclosure proves useful in opening up closed doors, that is, in overcoming certain tenacious resistances or impasses, thus allowing the treatment to move forward. On other occasions, however, self-disclosure may have an inhibitory effect that is not easily detected. The analyst has to be aware that, although on a manifest level the disclosure may enhance the patient's understanding of an aspect of her psychology, less consciously it may have the

unintended effect of increasing the patient's resistances. Understanding and interpretation of this covert reaction is vitally important if the patient is to progress in the analysis.

Some years ago I was working with a young woman with strongly obsessional features who tended to externalize her conflicts and to see her problems as resulting from the fault of others. For many months I interpreted this tenacious defensive structure with only a slight loosening of it becoming evident in sessions. I was relieved,

therefore, when in the third year of analysis the patient brought in some new and potentially important material. This had to do with the fact that at age 5 she had been sexually fondled by a beloved male cousin, a boy of 15, who regularly read to her at bedtime. While I did not believe that this experience was, by itself, the key to Ms K's neurosis, clearly it had a significant impact on her and I was eager to learn more about it.

As quickly as it had emerged, however, this material disappeared. It

went underground and in its stead the patient returned to the old complaints about friends and family. In response to this reactivated obsessional defense, often I found myself feeling bored and sleepy in sessions. On one occasion, partly to help keep alert, I picked up a notebook reserved for Ms K and began to leaf through the pages. Shortly thereafter I realized that she had heard what I was doing, but had chosen not to speak about it. I interpreted her avoidance, but quickly thereafter sought to explore her associations, to overhearing a man behind her making

strange noises. Ms K got the message and quickly began to relate the sounds that she heard in our session to the traumatic childhood experience with her cousin. This consisted of the boy reading to her, turning over pages in the book, and then slowly caressing her legs and genitals. While, clearly, these memories and the related material were of importance and were, in fact, stimulated by the noises that I made, by entering so rapidly into an exploration of this earlier experience, Ms K and I entered into a collusion. Not wanting to focus on my

countertransference response, and my inappropriate behavior—I had allowed myself to be distracted and had not been attuned to the patient—I led the patient down a path that while meaningful in its own right, was being used at the moment to avoid dealing with my own countertransference behavior. Ms K went along with me because she was terrified of her own anger and wished to avoid a potentially explosive confrontation. As a result, both of us joined together in the creation of a resistance that on the surface looked like meaningful

analytic exploration of an important experience in childhood.

I realized that if I continued on this track the patient would never again trust me as some part of her would know that she had been double-binded. When the time seemed right, therefore, I reviewed with Ms K what had happened between us, told her that her perceptions had been correct, that, in fact, my mind had wandered and that I had become distracted. In turn, Ms K told me that she knew that this was true, but had avoided confronting me

with the truth for fear of a clash between us that would lead to the ending of our relationship. Once the air was cleared in this way, we could go on to explore both the factors between us that contributed to my reaction and Ms K's need to keep me at a distance by unconsciously seeking to evoke such a response.

Some colleagues maintain that it is an error to acknowledge a mistake or a piece of countertransference behavior to the patient. This approach, they say, functions to alleviate the analyst's guilt

and does nothing to help the patient know themself. It is far better and more useful to investigate the patient's reactions to what they have perceived. In that way, they maintain, one is continually investigating the patient's psychology and avoiding unnecessary distractions. While I understand this thinking, I believe that it overlooks the profound effect on a patient of not acknowledging the truth of her perceptions. This puts the patient in a double-bind, leads to profound mistrust, and in my view, by enacting a deception, undermines the entire

treatment. I do not think that a patient will feel safe enough under these conditions to truly reveal the most vulnerable parts of herself.

In another situation, I found myself at times unable to make effective contact with a patient who, when angry, remained silent, withdrawn, and totally unapproachable. When retreating in this way, Mr D lay on the couch huddled over with knees drawn up, looking as though he was folded into himself. In many respects Mr D's withdrawal mimicked his father's

behavior. A bitter and angry man who suffered much physical trauma in his youth, the father spent long hours sitting alone in a dark living-room, silent and unapproachable. When as a boy Mr D tried to reach out to his father, he was either ignored or snapped at in a way that terrified the child. When he was angry at me, usually because I had missed a session or otherwise disappointed him, Mr D would retreat into his protective shell. Then nothing I would say or do would bring him out of it. There was, in fact, no interpretation that at one time or

another I did not offer. Typically, Mr D would listen, curl into himself and not respond. Only when he was ready to do so, usually several days later, would he begin to emerge from his fortress.

One day I returned from a brief vacation to find Mr D in a sullen, and angry mood. Huddled into himself as usual, he remained stubbornly silent. Totally unmovable in the face of my efforts to reach him. After offering a few interpretations having to do with Mr D's reaction to my absence and receiving no response whatsoever, I

found myself withdrawing, struggling with a wish to end the session and get away from this impossibly frustrating man. For some time the two of us sat in silence. The atmosphere in the room was heavy. Then, probably in response to the enormous frustration that I was feeling, I found myself speaking in a way that I had not done before.

'I would like to share with you what I am experiencing at this moment,' I said. 'I am sitting here feeling totally shut out, totally helpless. It is as though a steel door

has dropped down between us and there is absolutely no reaching you. And I know that no matter what I say or do, no matter in what way I knock at that door, it will remain shut tight. From what I am experiencing, from what I am feeling in my gut, I believe I know really in a way that I did not know before, how utterly helpless you must have felt as a child, trying to reach that unreachable man sitting in darkness. Because now I am that child and you are that man.'

Mr D was silent for a moment. Then, suddenly, he broke into tears and wept for fully five minutes. When he composed himself he remarked that although the essence of what I said was no different from what I had said many times before, he experienced my words in a totally new way. 'You really do know what it was like for me,' he said. 'I feel that for me that makes all the difference. Before, you were speaking words, ideas. Today you spoke feelings. I don't trust words, but I trust the honesty of raw feelings.'

For a number of years I have pondered over this response and its meaning. It addresses an aspect of psychoanalysis that is not well understood, but that seems of great importance. While clearly related to the communication of empathy, it involves something more. What is transmitted is a sense of authenticity communicated through affects that convey the analyst's identification with the patient's emotional experiences. For many patients this kind of response on the part of the analyst is more meaningful and evokes greater

trust than the more usual quiet empathy that is an inherent part of the analytic technique.

My final example is of a different sort. It illustrates a kind of difficulty that one may, at times, encounter in the use of self-disclosure. Mrs R was a woman who suffered early and severe losses that left her an angry, often embittered woman, but also a person who continually sought the approval of others. This conflict—the constant desire to express her pain and fury, on the one hand, and her fear of alienating

others on the other, caused Mrs R to be an expert at the indirect, oblique, subtly expressed, put-down. She also became an injustice collector, tallying every possible slight or hurt that came her way and using them as justification for the expression of her long-standing rage.

In our sessions Mrs R was often critical of me but always in an indirect way. Quoting so-called experts, she would sharply criticize psychoanalysis as well as colleagues with whom I worked. She was also indirectly

critical of my office, having negative things to say about old-fashioned doctors' offices, furnished in styles similar to mine. Quite remarkable was the fact that, although she would launch these attacks, Mrs R was quite unaware that she was being negative and critical toward me. Although I was accustomed to Mrs R's criticisms, on occasion they got to me. That happened one day when listening to Mrs R's attacks on colleagues, the field of analysis, and related issues, I found myself feeling tense. My body was tight, my guts felt knotted and my face

was flushed. Then, spontaneously, as happened with Mr K, I found myself speaking. ‘As I listen to what you are saying Mrs R,’ I began, ‘I am aware that I am feeling tense and ill at ease. My guts feel all roiled up and my whole body feels tight. And I realize that your comments are making me angry because indirectly, in the guise of criticizing others, you are actually attacking me and putting me down. But because your attack is indirect, it is hard to respond to it and this causes me to feel angry and helpless.’ There was silence in the room. Mrs R looked

surprised, then puzzled. ‘Does what I’ve said make any sense to you?’ I inquired. At that point I was feeling rather foolish and unprofessional for having come out so directly with what I was experiencing. I shuddered to think what my former supervisors would say if they heard me speak in this way.

‘Actually it does,’ Mrs R replied. ‘For years my husband has been telling me the same thing, that I’m always criticizing him and getting at him in an indirect, roundabout way. He

is so crazy himself, though, I don't listen to him, but if you, someone who I know well and trust are telling me the same thing, I have to take that seriously.'

Although I felt uneasy about my spontaneous self-disclosure, I was pleased by Mrs R's response to it. She was able to reflect on what I had said, take a step back, and examine herself in a way that she had not done before. She was, I thought, on the threshold of obtaining a new and centrally important insight about herself. In fact,

partly through my intervention, which stunned her, Mrs R came in touch, not only with the well of anger that was contained inside of her, but with her fear of expressing her rage and destroying needed relationships. That was all to the good, and I began to regard the kind of self-revelation that I had employed as quite a useful tool.

Then I learned something else. About a year later, when, once again, the matter of Mrs R's covert anger and my response to it arose, the patient described the impact that the earlier

session had had on her. ‘I was shocked and frightened by your response,’ she said. ‘Not that it wasn’t helpful; it was. I realized how much anger I was communicating and that was useful. But since then I realize that I have been holding back. I never thought that I could really get to you and your reaction frightened me. I became afraid that I could anger you to such an extent that you couldn’t take it. You would retaliate or, worse, blow up and simply quit the treatment. I didn’t want that, so without thinking about it, I

realize that I have been very careful about what I say and how I say it.'

Of course I should have picked up on this aspect of Mrs R's response and interpreted her reaction of fear and withdrawal. I did not, in part because the change was a subtle one, but also because I took the reduction in her anger and the shift in her behavior as positive changes that had developed as a result of the insights that she had obtained.

I cite this example to reiterate a truth that is well known to clinicians

and that is often forgotten. Patients will hear and respond to our interventions in ways that are quite different from what we intend. And their responses are often expressed in indirect, covert, and subterranean ways that are not readily apparent. If the analyst chooses to employ self-disclosure, therefore, it is necessary to not only be alert to these concealed responses, but to investigate with thoroughness, the unique way that the patient has processed this uniquely powerful type of intervention. A method that can, at times, help open

doors that seemed permanently closed, self-disclosure is also one that, if its consequences are insufficiently explored, has the potential to cause much trouble.

CONCLUSION

In this chapter, I have attempted to share some thoughts about aspects of analysis with which I have been concerned in recent years. These are also issues, I believe, to which comparatively little attention has been paid.

Perhaps the most important of these is the flow of non-verbal communication that is an integral part of every analytic hour. Closely connected to the enactments that bring to life the inner conflict of the patient, non-verbal communications are closely linked to key affects that fuel unconscious conflicts and fantasies. Not limited to our patients, non-verbal behavior and enactments constitute an ever-present part of the analyst's communications. Seeking always to use one's own subjective experiences in the service of understanding the

inner world of the patient, the analyst must decide when that understanding can be enhanced by sharing with the patient aspects of those experiences. A powerful tool that, at times, proves invaluable, self-disclosure is one that must be used selectively and with great care, for given the enormous impact of the analyst's words, it can have a profound and disruptive effect on the patient's sense of self.

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