The Analytic Third: Working with Intersubjective Clinical Facts

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ABSTRACT

In this paper, two clinical sequences are presented in an effort to describe the methods by which the analyst attempts to recognise, understand and verbally symbolise for himself and the analysand the specific nature of the moment-to-moment interplay of the analyst's subjective experience, the subjective experience of the analysand and the intersubjectively-generated experience of the analytic pair (the experience of the analytic third). The first clinical discussion describes how the intersubjective experience created by the analytic pair becomes accessible to the analyst in part through the analyst's experience of 'his own' reveries, forms of mental activity that often appear to be nothing more than narcissistic self-absorption, distractedness, compulsive rumination, daydreaming and the like. A second clinical account focuses on an instance in which the analyst's somatic delusion, in conjunction with the analysand's sensory experiences and body-related fantasies, served as a principal medium through which the analyst experienced and came to understand the meaning of the leading anxieties that were being (intersubjectively) generated.

And he is not likely to know what is to be done unless he lives in what is not merely the present, but the present moment of the past, unless he is conscious, not of what is dead, but of what is already living (T. S. Eliot, 1919, p. 11).

On this occasion of the celebration of the 75th anniversary of the founding of The International Journal of Psycho-Analysis, I shall endeavour to address an aspect of what I understand to be 'the present moment of the past' of psychoanalysis. It is my belief that an important facet of this 'present moment' for psychoanalysis is the development of an analytic conceptualisation of the nature of the interplay of subjectivity and intersubjectivity in the analytic setting and the exploration of the implications for technique that these conceptual developments hold.

In this paper, I shall present clinical material from two analyses in an effort to illustrate some of the ways in which an understanding of the interplay of subjectivity and intersubjectivity (Ogden, 1992a, 1992b) influences the practice of psychoanalysis and the way in which clinical theory is generated. As will be seen, I consider the dialectical movement of subjectivity and intersubjectivity to be a central clinical fact of psychoanalysis, which all clinical analytic thinking attempts to describe in ever more precise and generative terms.

The conception of the analytic subject, as elaborated in the work of Klein and Winnicott, has led to an increasingly strong emphasis on the interdependence of subject and object in psychoanalysis (Ogden, 1992b). I believe that it is fair to say that contemporary psychoanalytic thinking is approaching a point where one can no longer simply speak of the analyst and the analysand as separate subjects who take one another as objects. The idea of the analyst as a neutral blank screen for the patient's projections is occupying a position of steadily diminishing importance in current conceptions of the analytic process.

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Over the past fifty years, psychoanalysts have changed their view of their own method. It is now widely held that, instead of being about the patient's intrapsychic dynamics, interpretation should be made about the interaction of patient and analyst at an intrapsychic level (O'Shaughnessy, 1983p. 281).

My own conception of analytic intersubjectivity places central emphasis on its dialectical nature (Ogden, 1979).
This understanding represents an elaboration and extension of Winnicott's notion that "There is no such thing as an infant" [apart from the maternal provision] (quoted in Winnicott, 1960p. 39, fn.). I believe that, in an analytic context, there is no such thing as an analysand apart from the relationship with the analyst, and no such thing as an analyst apart from the relationship with the analysand. Winnicott's statement is, I believe, intentionally incomplete. He assumes that it will be understood that the idea that there is no such thing as an infant is playfully hyperbolic and represents one element of a larger paradoxical statement. From another perspective (from the point of view of the other 'pole' of the paradox), there is obviously an infant and a mother who constitute separate physical and psychological entities. The mother–infant unity coexists in dynamic tension with the mother and infant in their separateness.

Similarly, the intersubjectivity of the analyst–analysand coexists in dynamic tension with the analyst and the analysand as separate individuals with their own thoughts, feelings, sensations, corporal reality, psychological identity and so on. Neither the intersubjectivity of the mother–infant nor that of the analyst–analysand (as separate psychological entities) exists in pure form. The intersubjective and the individually subjective each create, negate and preserve the other (see Ogden, 1992b, for a discussion of the dialectic of oneness and twoness in early development and in the analytic relationship). In both the relationship of mother and infant and of analyst and analysand, the task is not to tease apart the elements constituting the relationship in an effort to determine which qualities belong to each individual participating in it; rather, from the point of view of the interdependence of subject and object, the analytic task involves an attempt to describe as fully as possible the specific nature of the experience of the interplay of individual subjectivity and intersubjectivity.

In the present paper, I shall attempt to trace in some detail the vicissitudes of the experience of being simultaneously within and outside of the intersubjectivity of the analyst–analysand, which I will refer to as 'the analytic third'. This third subjectivity, the intersubjective analytic third Green's [1975] 'analytic object'), is a product of a unique dialectic generated by (between) the separate subjectivities of analyst and analysand within the analytic setting.

I will present portions of two analyses which highlight different aspects of the dynamic interplay of subjectivities constituting the analytic third. The first fragment of an analysis focuses on the importance of the most mundane,


2 Although, for convenience sake, I shall at times refer to the intersubjective analytic third as 'the analytic third', or simply 'the third', this concept should not be confused with the oedipal/symbolic third (the Lacanian [1953] 'name of the father'). The latter concept refers to a 'middle term' that stands between symbol and symbolised, between oneself and one's immediate lived sensory experience, thereby creating a space in which the interpreting, self-reflective, symbolising subject is generated. In early developmental terms, it is the father (or the 'father-in-the-mother', Ogden, 1987) who intercedes between the mother and infant (or, more accurately, the mother-infant), thus creating the psychological space in which the elaboration of the depressive position and oedipal triangulation occurs.

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CLINICAL ILLUSTRATION: THE PURLOINED LETTER

In a recent meeting with Mr L, an analysand with whom I had been working for about three years, I found myself looking at an envelope on the table next to my chair in my consulting room. For the previous week or ten days, I had been using this envelope to jot down phone numbers retrieved from my answering machine, ideas for classes I was teaching, errands I had to attend to, and other notes to myself. Although the envelope had been in plain view for over a week, until that moment in the meeting I had not noticed that there was a series of vertical lines in the lower right-hand portion of the front of the envelope, markings which seemed to indicate that the letter had been part of a bulk mailing. I was taken aback by a distinct feeling of disappointment: the letter that had arrived in the envelope was from a colleague in Italy, who had written to me about a matter that he felt was delicate and should be kept in strictest confidence between us.

I then looked at the stamps and for the first time noticed two further details. The stamps had not been cancelled, and one of the three stamps had words on it that to my surprise I could read. I saw the words 'Wolfgang Amadeus Mozart' and realised after a moment's delay that the words were a name with which I was familiar and were 'the same' in Italian as in English.

As I retrieved myself from this reverie, I wondered how this might be related to what was currently going on between myself and the patient. The effort to make this shift in psychological states felt like the uphill battle of attempting to 'fight repression' that I have experienced while attempting to remember a dream that is slipping away on waking. In years past, I have put aside such 'lapses of attention' and endeavoured to devote myself to making sense of what the patient was saying, since, in returning from such reveries, I am inevitably a bit behind the patient.

I realised that I was feeling suspicious about the genuineness of the intimacy that the letter had seemed to convey. My fleeting fantasy that the letter had been part of a bulk mailing reflected a feeling that I had been duped. I felt that I had been naive and gullible, ready to believe that I was being entrusted with a special secret. I had a number of fragmentary associations, which included the image of a mail sack full of letters with stamps that had not been cancelled, a spider's egg sac, Charlotte's Web, Charlotte's message on the cobweb, Templeton the rat, and innocent Wilbur. None of these thoughts seemed to scratch the surface of what was occurring between Mr L and myself: I felt as if we were simply going through the motions of countertransference analysis, in a way that seemed forced.

As I listened to Mr L, a 45-year-old director of a large non-profit-making agency, I was aware that he was talking in a way that was highly characteristic of him—he sounded weary and hopeless, and yet was doggedly trudging on with his production of 'free associations'. During the entire period of the analysis, Mr L had been struggling mightily to escape the confines of his extreme emotional detachment both from himself and from other people. I thought of his description of his driving up to the house in which he lives and not being able to feel it was his house. When he walked inside, he was greeted by 'the woman and four children who lived there', but could not feel they were his wife and his children. 'It's a sense of myself not being in the picture and yet I'm there. In that second of recognition of not fitting in, it's a feeling of being separate, which is right next to feeling lonely.'

I tried out in my own mind the idea that perhaps I felt duped by him and taken in by the apparent sincerity of his effort to talk to me; but this idea rang hollow to me. I was reminded of the frustration in Mr L's voice as he explained to me again and again that he knew that he must be feeling something, but he did not have a clue what it might be.

The patient's dreams were regularly filled with images of paralysed people, prisoners, and mutes. In a recent dream he had succeeded, after expending enormous energy, in breaking open a stone, only to find hieroglyphics carved into the interior of the stone (like a fossil). His initial joy was extinguished by his recognition that he could not understand a single element of the meaning of the hieroglyphics. In the dream, his discovery was momentarily exciting, but ultimately an empty, painfully tantalising experience that left him in deep despair. Even the feeling of despair was almost immediately obliterated upon awakening and became a lifeless set of dream images that he 'reported' to me (as opposed to telling to me). The dream had become a sterile memory and no longer felt alive as a set of feelings.

I considered the idea that my own experience in the hour might be thought of as a form of projective identification in which I was participating in the patient's experience of despair at being unable to discern and experience an inner life that seemed to lie behind an impenetrable barrier. This formulation made intellectual sense, but felt clichéd and emotionally lacking. I then drifted into a series of narcissistic, competitive thoughts concerning professional matters, which began to take on a ruminative quality. These ruminations were unpleasantly interrupted
by the realisation that my car, which was in a repair shop, would have to be collected before 6:00 p.m., when the shop closed. I would have to be careful to end the last analytic hour of the day at precisely 5:50 p.m. if there were to be any chance at all of my getting to the garage before it closed. In my mind, I had a vivid image of myself standing in front of the closed garage doors with the traffic roaring behind me. I felt an intense helplessness and rage (as well as some self-pity) about the way in which the owner of the garage had shut his doors at precisely 6:00 p.m., despite the fact that I had been a regular customer for years and he knew full well that I would need my car. In this fantasised experience, there was a profound, intense feeling of desolation and isolation, as well as a palpable physical sensation of the hardness of the pavement, the smell of the stench of the exhaust fumes, and the grittiness of the dirty glass garage-door windows.

Although at the time I was not fully conscious of it, in retrospect I can better see that I was quite shaken by this series of feelings and images, which had begun with my narcissistic/competitive ruminations and had ended with the fantasies of impersonally ending the hour of my last patient of the day and then being shut out by the owner of the garage.

As I returned to listening in a more focused way to Mr L, I laboured to put together the things that he was currently discussing: his wife's immersion in her work and the exhaustion that both he and his wife felt at the end of the day; his brother-in-law's financial reversals and impending bankruptcy; an experience while jogging, in which the patient was involved in a near accident with a motor-cyclist who was riding recklessly. I could have taken up any one of these images as a symbol of the themes that we had previously discussed, including the very detachment that seemed to permeate all that the patient was talking about, as well as the disconnection I felt both from him and from myself. However, I decided not to intervene, because it felt to me that if I were to try to offer an interpretation at this point I would only be repeating myself and saying something for the sake of reassuring myself that I had something to say.

The phone in my office had rung earlier in the meeting and the answering machine had clicked twice to record a message before resuming its silent vigil. At the time of the call, I had not consciously thought about who might be calling, but at this point in the hour I checked the clock to see how much longer it would be before I could retrieve the message. I felt relieved to think of the sound of a fresh voice on the answering-machine tape. It was

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not that I imagined finding a specific piece of good news; it was more that I yearned for a crisp, clear voice. There was a sensory component to the fantasy—I could feel a cool breeze wash across my face and enter my lungs relieving the suffocating stillness of an overheated, unventilated room. I was reminded of the fresh stamps on the envelope—clear, vibrant in their colours, unobscured by the grim, mechanical, indelible scarring of machine-made cancellation marks.

I looked again at the envelope and noticed something that I had been only subliminally aware of all along: my name and address had been typed on a manual typewriter—not a computer, not a labelling machine, not even an electric typewriter. I felt almost joyous about the personal quality with which my name had been 'spoken'. I could almost hear the idiosyncratic irregularities of each typed letter: the inexactness of the line, the way in which each 't' was missing its upper portion above the bar. This felt to me like the accent and inflection of a human voice speaking to me, knowing my name.

These thoughts and feelings, as well as the sensations associated with these fantasies, brought to mind (and body) something that the patient had said to me months earlier, but subsequently had not mentioned. He had told me that he felt closest to me not when I said things that seemed right, but when I made mistakes, when I got things wrong. It had taken me these months to understand in a fuller way what he had meant when he had said this to me. At that point in the meeting, I began to be able to describe for myself the feelings of desperateness that I had been feeling in my own and the patient's frantic search for something human and personal in our work together. I also began to feel that I understood something of the panic, despair and anger associated with the experience of colliding again and again with something that appears to be human, but feels mechanical and impersonal.

I was reminded of Mr L's description of his mother as 'brain dead'. The patient could not remember a single instance of her ever having shown any evidence of feeling anger or an intense feeling of any sort. She immersed herself in housework and 'completely uninspired cooking'. Emotional difficulties were consistently met with platitudes. For example, when the patient, as a 6-year-old, was terrified each night that there were creatures under his bed, his mother would tell him, 'There's nothing there to be afraid of'. This statement became a symbol in the analysis of the discord between the accuracy of the statement, on the one hand (there were, in fact, no creatures under his bed), and, on the other, the unwillingness/ inability of his mother to recognise the inner life of the patient (there was
something he was frightened of that she refused to acknowledge, identify with or even be curious about).

Mr L's chain of thoughts—which included the idea of feeling exhausted, his brother-in-law's impending bankruptcy, and the potentially serious or even fatal accident—now struck me as a reflection of his unconscious attempts to talk to me about his inchoate feeling that the analysis was depleted, bankrupt, and dying. He was experiencing the rudiments of a feeling that he and I were not talking to one another in a way that felt alive; rather, I seemed to him unable to be other than mechanical with him, just as he was unable to be human with me.

I told the patient that I thought that our time together must feel to him like a joyless obligatory exercise, something like a factory job where one punches in and out with a time card. I then said that I had the sense that he sometimes felt so hopelessly stifled in the hours with me that it must have felt like being suffocated in something that appears to be air, but is actually a vacuum.

Mr L's voice became louder and fuller in a way that I had not heard before as he said, 'Yes, I sleep with the windows wide open for fear of suffocating during the night. I often wake up terrified that someone is suffocating me as if they have put a plastic bag over my head'. The patient went on to say that when he walked into my consulting room, he regularly felt that the room was too warm and that the air was disturbingly still. He said that it had never once occurred to him to ask me either to turn off the heater at the foot of the couch or to open a window, in large part because he had not been fully aware until then that he had had such feelings. He said that it was terribly discouraging to realise how little he allowed himself to know about what was going on inside of him, even to the point of not knowing when a room felt too warm to him.

Mr L was silent for the remaining fifteen minutes of the session. A silence of that length had not previously occurred in the analysis. During that silence, I did not feel pressured to talk. In fact, there was a considerable feeling of repose and relief in the respite from what I now viewed as the 'anxious mentation' that had so often filled the hours. I became aware of the tremendous effort that Mr L and I regularly expended in an effort to keep the analysis from collapsing into despair: I imagined the two of us in the past frantically trying to keep a beach ball in the air, punching it from one to the other. Toward the end of the hour, I became drowsy and had to fight off sleep.

The patient began the next meeting by saying that he had been awakened by a dream early that morning. In the dream

he was underwater and could see other people, who were completely naked. He noticed that he too was naked, but he did not feel self-conscious about it. He was holding his breath and felt panicky that he would drown when he could no longer hold his breath. One of the men, who was obviously breathing underwater without difficulty, told him that it would be okay if he breathed. He very warily took a breath and found that he could breathe. The scene changed, although he was still underwater. He was crying in deep sobs and was feeling a profound sadness. A friend, whose face he could not make out, talked to him. Mr L said that he felt grateful to the friend for not trying to reassure him or cheer him up.

The patient said that when he awoke from the dream he felt on the verge of tears. He said he had got out of bed because he just wanted to feel what he was feeling, although he did not know what he was sad about. Mr L noticed the beginnings of his familiar attempts to change the feeling of sadness into feelings of anxiety about office business or worry about how much money he had in the bank, or other matters with which he 'distracts' himself.

**DISCUSSION**

The foregoing account was offered not as an example of a watershed in an analysis, but rather in an effort to convey a sense of the dialectical movement of subjectivity and intersubjectivity in the analytic setting. I have attempted to describe something of the way in which my experience as an analyst (including the barely perceptible and often extremely mundane background workings of my mind) are contextualised by the intersubjective experience created by analyst and analysand. No thought, feeling or sensation can be considered to be the same as it was or will be outside of the context of the specific (and continually shifting) intersubjectivity created by analyst and analysand.

I would like to begin the discussion by saying that I am well aware that the form in which I have presented the clinical material was a bit odd, in that I give almost no information of the usual sort about Mr L until rather late in the presentation. This was done

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3 What I have said here about the analyst's thoughts and feelings being in every instance contextualised, and therefore altered, by
the experience with the patient might seem to lead to the conclusion that everything the analyst thinks and feels should be considered countertransference. However, I believe the use of the term countertransference to refer to everything the analyst thinks and feels and experiences sensorially, obscures the simultaneity of the dialectic of oneness and twoness, of individual subjectivity and intersubjectivity that is the foundation of the psychoanalytic relationship. To say that everything the analyst experiences is countertransference is only to make the self-evident statement that we are each trapped in our own subjectivity. For the concept of countertransference to have more meaning than this, we must continually re-ground the concept in the dialectic of the analyst as a separate entity and the analyst as a creation of the analytic intersubjectivity. Neither of these 'poles' of the dialectic exists in pure form and our task is to make increasingly full statements about the specific nature of the relationship between the experience of subject and object, between countertransference and transference at any given moment.

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in an effort to convey a sense of the degree to which Mr L was at times quite absent from my conscious thoughts and feelings. My attention was not at all focused on Mr L during these periods of 'reverie' (I use Bion's term reverie to refer not only to those psychological states that clearly reflect the analyst's active receptivity to the analysand, but also to a motley collection of psychological states that seem to reflect the analyst's narcissistic self-absorption, obsessional rumination, day-dreaming, sexual fantasising, and so on).

Turning to the details of the clinical material itself as it unfolded, my experience of the envelope (in the context of this analysis) began with my noticing the envelope, which, despite the fact that it had been physically present for weeks, at that moment came to life as a psychological event, a carrier of psychological meanings, that had not existed prior to that moment. I view these new meanings not simply as a reflection of a lifting of a repression within me; rather, I understand the event as a reflection of the fact that a new subject (the analytic third) was being generated by (between) Mr L and myself, which resulted in the creation of the envelope as an 'analytic object' (Bion, 1962); (Green, 1975). When I noticed this 'new object' on my table, I was drawn to it in a way that was so completely ego-syntonic as to be an almost completely unselfconscious event for me. I was struck by the machine-made markings on the envelope, which again had not been there (for me) up to this point: I experienced these markings for the first time in the context of a matrix of meanings having to do with disappointment about the absence of a feeling of being spoken to in a way that felt personal. The uncancellation stamps were similarly 'created' and took their place in the intersubjective experience that was being elaborated. Feelings of estrangement and foreignness mounted to the point where I hardly recognised Mozart's name as a part of a 'common language'.

A detail that requires some explanation is the series of fragmentary associations having to do with Charlotte's Web. Although highly personal and idiosyncratic to my own life experience, these thoughts and feelings were also being created anew within the context of the experience of the analytic third. I had consciously known that Charlotte's Web was very important to me, but the particular significance of the book was not only repressed, but had also not yet come into being in such a way that it would exist in this hour. It was not until weeks after the meeting being described that I became aware that this book was originally (and was in the process of becoming) intimately associated with feelings of loneliness. I realised for the first time (in the following weeks) that I had read this book several times during a period of intense loneliness in my childhood, and that I had thoroughly identified with Wilbur as a misfit and outcast. I view these (largely unconscious) associations to Charlotte's Web not as a recollection of a memory that had been repressed, but as the creation of an experience (in and through the analytic intersubjectivity) that had not previously existed in the form that it was now taking. This conception of analytic experience is central to the current paper: the analytic experience occurs on the cusp of the past and the present, and involves a 'past' that is being created anew (for both analyst and analysand) by means of an experience generated between analyst and analysand (i.e. within the analytic third).

Each time my conscious attention shifted from the experience of 'my own' reveries to what the patient was saying and how he was saying it to me and being with me, I was not 'returning' to the same place I had left seconds or minutes earlier. In each instance, I was changed by the experience of the reverie, sometimes only in an imperceptibly small way. In the course of the reverie just described, something had occurred that is in no way to be considered magical or mystical. In fact, what occurred was so ordinary, so unobtrusively mundane, as to be almost unobservable as an analytic event.

When I refocused my attention on Mr L after the series of thoughts and feelings concerning the envelope, I was more receptive to the schizoid quality of his experience and to the hollowness of both his and my own attempts to create something together that felt real. I was more keenly aware of the feeling

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of arbitrariness associated with his sense of his place in his family and the world, as well as the feeling of emptiness associated with my own efforts at being an analyst for him.

I then became involved in a second series of self-involved thoughts and feelings (following my only partially satisfactory attempt to conceptualise my own despair and that of the patient in terms of projective identification). My thoughts were interrupted by anxious fantasies and sensations concerning the closing of the garage and my need to end the last analytic hour of the day 'on time'. My car had been in the garage the entire day, but it was only with Mr L at precisely that moment that the car as analytic object was created. The fantasy involving the closing of the garage was created at that moment not by me in isolation, but through my participation in the intersubjective experience with Mr L. Thoughts and feelings concerning the car and the garage did not occur in any of the other analytic hours in which I participated during that day.

In the reverie concerning the closing of the garage and my need to end the last analytic hour of the day 'on time', the experience of bumping up against immovable mechanical inhumaness in myself and others was repeated in a variety of forms. Interwoven with the fantasies were sensations of hardness (the pavement, glass and grit) and suffocation (the exhaust fumes). These fantasies generated a sense of anxiety and urgency within me that was increasingly difficult for me to ignore (although in the past I might well have dismissed these fantasies and sensations as having no significance for the analysis except as an interference to be overcome).

'Returning' to listening to Mr L, I was still feeling quite confused about what was occurring in the session and was sorely tempted to say something to dissipate my feelings of powerlessness. At this point, an event that had 'occurred' earlier in the hour (the phone call recorded by the answering machine), occurred for the first time as an analytic event (that is, as an event that held meaning within the context of the intersubjectivity that was being elaborated). The 'voice' recorded on the answering-machine tape now held the promise of being the voice of a person who knew me and would speak to me in a personal way. The physical sensations of breathing freely and suffocating were increasingly important carriers of meaning. The envelope became a still different analytic object from the one that it had been earlier in the hour: it now held meaning as a representation of an idiosyncratic, personal voice (the hand-typed address with an imperfect 't').

The cumulative effect of these experiences within the analytic third led to the transformation of something the patient had said to me months earlier about feeling closest to me when I made mistakes. The patient's statement took on new meaning, but I think it would be more accurate to say that the (remembered) statement was now a new statement for me, and in this sense was being made for the first time.

At this point in the hour, I began to be able to use language to describe for myself something of the experience of confronting an aspect of another person, and of myself, that felt frighteningly and irrevocably inhuman. A number of the themes that Mr L had been talking about now took on a coherence for me that they had not held before: the themes now seemed to me to converge on the idea that Mr L was experiencing me and the discourse between us as bankrupt and dying. Again, these 'old' themes were now (for me) becoming new analytic objects that I was encountering freshly. I attempted to talk to the patient about my sense of his experience of me and the analysis as mechanical and inhuman. Before I began the intervention, I did not consciously plan to use the imagery of machines (the factory and the time clock) to convey what I had in mind; I was unconsciously drawing on the imagery of my reveries concerning the mechanical (clock-determined) ending of an analytic hour and the closing of the garage. I view my 'choice' of imagery as a reflection of the way in which I was 'speaking from' the unconscious experience of

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4 I believe that an aspect of the experience I am describing can be understood in terms of projective identification, but the way in which it was utilised, at the point when it arose, was predominantly in the service of an intellectualising defence.

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the analytic third (the unconscious intersubjectivity being created by Mr L and myself). At the same time, I was speaking about the analytic third from a position (as analyst) outside of it.

I went on in an equally unplanned way to tell the patient of an image of a vacuum chamber (another machine), in which something that appeared to be life-sustaining air was, in fact, emptiness (here, I was unconsciously drawing on the sensation-images of the fantasised experience of exhaust-filled air outside the garage and the breath of fresh air associated with the answering-machine fantasy). Mr L's response to my intervention involved a fullness of voice that reflected a fullness of breathing (a fuller giving and taking). His own conscious and unconscious feelings of being foreclosed from the human had been experienced in the form of images and sensations of suffocation at the hands of the killing mother/analyst (the plastic bag [breast] that prevented him from being filled with life-sustaining air).
The silence at the end of the hour was in itself a new analytic event and reflected a feeling of repose that stood in marked contrast to the image of being violently suffocated in a plastic bag or of feeling disturbingly stifled by the still air in my consulting room. There were two additional aspects of my experience during this silence that held significance: the fantasy of a beach ball being frantically kept aloft by being punched between Mr L and myself, and my feeling of drowsiness. Although I felt quite soothed by the way in which Mr L and I were able to be silent together (in a combination of despair, exhaustion and hope), there was an element in the experience of the silence (in part, reflected in my somnolence) that felt like faraway thunder (which I retrospectively view as warded-off anger).

I shall only comment briefly on the dream with which Mr L opened the next hour. I understand it as simultaneously a response to the previous hour and the beginnings of a sharper delineation of an aspect of the transference—countertransference, in which Mr L's fear of the effect of his anger on me and of his homosexual feelings toward me were becoming predominant anxieties (earlier on, I had had clues about these, which I had been unable to use as analytic objects, e.g. the image and sensation of roaring traffic behind me in my garage fantasy).

In the first part of the dream,

the patient was underwater with other naked people, including a man who told him that it would be alright to breathe, despite his fear of drowning. As he breathed, he found it hard to believe he was really able to do so.

In the second part of Mr L's dream,

he was sobbing with sadness while a man, whose face he could not make out, stayed with him but did not try to cheer him up.

I view this dream as in part an expression of Mr L's feeling that in the previous hour the two of us had together experienced and begun to better understand something important about his unconscious ('underwater') life and that I was not afraid of being overwhelmed (drowned) by his feelings of isolation, sadness and futility, nor was I afraid for him. As a result, he dared to allow himself to be alive (to inhale) that which he formerly feared would suffocate him (the vacuum breast/analyst). In addition, there was a suggestion that the patient's experience did not feel entirely real to him in that, in the dream, he found it hard to believe he was really able to do what he was doing.

In the second portion of Mr L's dream, he represented more explicitly his enhanced ability to feel his sadness in such a way that he felt less disconnected from himself and from me. The dream seemed to me to be in part an expression of gratitude to me for not having robbed the patient of the feelings he was beginning to experience, i.e. for not interrupting the silence at the end of the previous day's meeting with an interpretation or otherwise attempting to dissipate or even transform his sadness with my words and ideas.

I felt that, in addition to the gratitude (mixed with doubt) that Mr L was experiencing

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5 It was in this indirect way (i.e. in allowing myself to draw freely upon my unconscious experience with the patient in constructing my interventions) that 'I told' the patient about my own experience of the analytic third. This indirect communication of the countertransference contributes in a fundamental way to the feeling of spontaneity, aliveness and authenticity of the analytic experience.

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in connection with these events, there were less-acknowledged feelings of ambivalence toward me. I was partly alerted to this possibility by my own drowsiness at the end of the previous hour, which often reflects my own state of defendedness. The fantasy of punching the beach ball (breast) suggested that it might well be anger that was being warded off. Subsequent events in the analysis led me to feel increasingly convinced that the facelessness of the man in the second portion of the dream was in part an expression of the patient's (maternal transference) anger at me for being so elusive as to be shapeless and nondescript (as he felt himself to be). This idea was borne out in the succeeding years of analysis as Mr L's anger with me for 'being nobody in particular' was directly expressed. In addition, on a more deeply unconscious level, the patient's being invited by the naked man to breathe in the water reflected what I felt to be an intensification of Mr L's unconscious feeling that I was seducing him into being alive in the room with me in a way that often stirred homosexual anxiety (represented by the naked man's encouraging Mr L to take the shared fluid into his mouth). The sexual anxiety reflected in this dream was not interpreted until much later in the analysis.

**SOME ADDITIONAL COMMENTS**

In the clinical sequence described above, it was not simply fortuitous that my mind 'wandered' and came to focus on a machine-made set of markings on an envelope covered by scribblings of phone numbers, notes for teaching and
reminders about errands that needed to be done. The envelope itself, in addition to carrying the meanings already mentioned, also represented (what had been) my own private discourse, a private conversation not meant for anyone else; written on it were notes in which I was talking to myself about the details of my life. The workings of the analyst's mind during analytic hours in these unconscious, 'natural' ways are highly personal, private and embarrassingly mundane aspects of life that are rarely discussed with colleagues, much less written about in published accounts of analysis. It requires great effort to seize this aspect of the personal and the everyday from the unself-reflective area of reverie for the purpose of talking to ourselves about the way in which this asset of experience has been transformed such that it has become a manifestation of the interplay of analytic subjects. The 'personal' (the individually subjective) is never again simply what it had been prior to its creation in the intersubjective analytic third, nor is it entirely different from what it had been.

I believe that a major dimension of the analyst's psychological life in the consulting room with the patient takes the form of reverie concerning the ordinary, everyday details of his own life (that are often of great narcissistic importance to him). In this clinical discussion, I have attempted to demonstrate that these reveries are not simply reflections of inattentiveness, narcissistic self-involvement, unresolved emotional conflict, and the like; rather, this psychological activity represents symbolic and proto-symbolic (sensation-based) forms given to the unarticulated (and often not yet felt) experience of the analysand as they are taking form in the intersubjectivity of the analytic pair (i.e. in the analytic third).

This form of psychological activity is often viewed as something that the analyst must get through, put aside, overcome, etc. in his effort to be both emotionally present with and attentive to the analysand. I am suggesting that a view of the analyst's experience that dismisses this category of clinical fact leads the analyst to diminish (or ignore) the significance of a great deal (in some instances, the majority) of his experience with the analysand. I feel that a principal factor contributing to the underevaluation of such a large portion of the analytic experience is the fact that such acknowledgement involves a disturbing form of self-consciousness. The analysis of this aspect of the transference—countertransference requires an examination of the way we talk to ourselves and what we talk to ourselves about in a private, relatively-undefended psychological state. In this state, the dialectical interplay of consciousness and unconsciousness has been altered in ways that resemble a dream state. In becoming self-conscious in this way, we are tampering with an essential inner sanctuary of privacy.

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and therefore with one of the cornerstones of our sanity. We are treading on sacred ground, an area of personal isolation in which, to a large extent, we are communicating with subjective objects (Winnicott, 1963); (see also Ogden, 1991). This communication (like the notes to myself on the envelope) are not meant for anyone else, not even for aspects of ourselves that lie outside of this exquisitely-private/mundane 'cul-de-sac' (Winnicott, 1963p. 184). This realm of transference—countertransference experience is so personal, so ingrained in the character structure of the analyst, that it requires great psychological effort to enter into a discourse with ourselves in a way that is required to recognise that even this aspect of the personal has been altered by our experience in and of the analytic third. If we are to be analysts in a full sense, we must self-consciously attempt to bring even this aspect of ourselves to bear on the analytic process.

**THE PSYCHE-SOMA AND THE ANALYTIC THIRD**

In the following section of this paper, I will present an account of an analytic interaction in which a somatic delusion experienced by the analyst, and a related group of bodily sensations and body-related fantasies experienced by the analysand, constituted a principal medium through which the analytic third was experienced, understood, and interpreted. As will become evident, the conduct of this phase of the analysis depended on the analyst's capacity to recognise and make use of a form of intersubjective clinical fact manifested largely through bodily sensation/fantasy.

**Clinical Illustration: The Tell-Tale Heart**

In this clinical discussion, I shall describe a series of events that occurred in the third year of the analysis of Mrs B, a 42-year-old, married lawyer and mother of two latency-aged children. The patient had begun analysis for reasons that were not clear to either of us; she had felt vague discontent with her life, despite the fact that she had 'a wonderful family' and was doing well in her work. She told me that she never would have guessed that she would have 'ended up in an analyst's office'; 'It feels like I've stepped out of a Woody Allen film'.

The first year-and-a-half of analysis had a laboured and vaguely unsettling feeling to it. I was puzzled by why Mrs B was coming to her daily meetings and was a bit surprised each day when she appeared. The patient almost
never missed a meeting, was rarely late and, in fact, arrived early enough to use the lavatory in my office suite prior to almost every meeting.

Mrs B spoke in an organised, somewhat obsessional but thoughtful way; there were always 'important' themes to discuss, including her mother's jealousy of even small amounts of attention paid to the patient by her father. Mrs B felt that this was connected with current difficulties such as her inability to learn ('take things in') from female senior partners at work. Nonetheless, there was a superficiality to this work and as time went on it seemed to require greater and greater effort for the patient to 'find things to talk about'. The patient talked about not feeling fully present in the meetings, despite her best efforts to 'be here'.

By the end of the second year of analysis, the silences had become increasingly frequent and considerably longer in duration, often lasting fifteen to twenty minutes (in the first year, there had rarely been a silence). I attempted to talk with Mrs B about what it felt like for her to be with me in a given period of silence. She would reply that she felt extremely frustrated and stuck, but was unable to elaborate. I offered my own tentative thoughts about the possible relationship between a given silence and the transference–countertransference experience that might have immediately preceded the silence or perhaps been left unresolved in the previous meeting. None of these interventions seemed to alter the situation.

Mrs B repeatedly apologised for not having more to say and worried that she was failing me. As the months passed, there was a growing feeling of exhaustion and despair associated with the silences and with the overall lifelessness of the analysis. The patient's apologies to me for this state of affairs continued, but became increasingly unspoken and were conveyed by her facial expression, gait, tone of voice, etc. In addition, at this juncture in the analysis, Mrs B also began to wring her hands throughout the analytic hours, and yet more vigorously during the silences. She pulled strenuously on the fingers of her hands and deeply kneaded her knuckles and fingers to the point that her hands became reddened in the course of the hour.

I found that my own fantasies and day-dreams were unusually sparse during this period of work. I also noticed that I experienced less of a feeling of closeness to Mrs B than I would have expected. One morning while driving to my office, I was thinking of the people I would be seeing that day and could not remember Mrs B's first name. I rationalised that I had recorded only her last name in my appointment book and never addressed her by her first name — nor did she ever mention her first name in talking about herself, as many patients do. I imagined myself as a mother unable to give her baby a name after its birth as a result of profound ambivalence concerning the birth of the baby. Mrs B had told me very little about her parents and her childhood. She said that it was terribly important to her that she tell me about her parents in a way that was both 'fair and accurate'. She said that she would tell me about them when she found the right way and the right words to do so.

During this period I developed what I felt to be a mild case of the 'flu, but was able to keep my appointments with all of my patients. In the weeks that followed, I noticed that I continued to feel physically unwell during my meetings with Mrs B, experiencing feelings of malaise, nausea and vertigo. I felt like a very old man and, for reasons I could not understand, I took some comfort in this image of myself, while at the same time deeply resenting it. I was not aware of similar feelings and physical sensations during any other parts of the day. I concluded that this reflected a combination of the fact that the meetings with Mrs B must have been particularly draining for me and that the long periods of silence in her meetings allowed me to be more self-conscious of my physical state than I was with other patients.

In retrospect, I am able to recognise that during this period I began to feel a diffuse anxiety during the hours with Mrs B. However, at the time I was only subliminally aware of this anxiety and was hardly able to differentiate it from the physical sensations I was experiencing. Just before my sessions with Mrs B, I would regularly find things to do, such as making phone calls, sorting papers, finding a book, etc., all of which had the effect of delaying the moment when I would have to meet the patient in the waiting room. As a result, I was occasionally a minute or so late in beginning the hours.

Mrs B seemed to look at me intently at the beginning and end of each hour. When I asked her about it, she apologised and said that she was not aware of doing so. The content of the patient's associations had a sterile, highly controlled feeling to it and centred on her difficulties at work and worries about the emotional troubles that she felt her children might be having—she brought her older child for a consultation with a child psychiatrist because of her worry that he could not concentrate well enough in school. I commented that I thought Mrs B was worried about her own value as a mother just as she was worried about her value as a patient (this interpretation was partially correct,
but failed to address the central anxiety of the hour because, as I will discuss, I was unconsciously defending against recognising it.

Soon after I made the intervention concerning the patient's self-doubts concerning her value as a mother and analysand, I felt thirsty and leaned over in my chair to take a sip from a glass of water that I keep on the floor next to my chair (I had on many occasions done the same thing during Mrs B's hours, as well as with other patients). Just as I was reaching for the glass, Mrs B startled me by abruptly (and for the first time in the analysis) turning around on the couch to look at me. She had a look of panic on her face and said, 'I'm sorry, I didn't know what was happening to you'.

It was only in the intensity of this moment, in which there was a feeling of terror that something catastrophic was happening to me, that I was able to name for myself the terror that I had been carrying for some time. I

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became aware that the anxiety I had been feeling and the (predominantly unconscious and primitively symbolised) dread of the meetings with Mrs B (as reflected in my procrastinating behaviour) had been directly connected with an unconscious sensation/fantasy that my somatic symptoms of malaise, nausea and vertigo were caused by Mrs B, and that she was killing me. I now understood that for several weeks I had been emotionally consumed by the unconscious conviction (a 'fantasy in the body', Gaddini, 1982, p. 143) that I had a serious illness, perhaps a brain tumour, and that during that period I had been frightened that I was dying. I felt an immense sense of relief at this point in the meeting as I came to understand these thoughts, feelings and sensations as reflection of transference–countertransference events occurring in the analysis. In response to her turning to me in fright, I said to Mrs B that I thought she had been afraid that something terrible was happening to me and that I might even be dying. She said that she knew it sounded crazy, but when she heard me moving in my chair she became filled with the feeling that I was having a heart attack. She added that she had felt that I had looked ashen for some time, but she had not wanted to insult me or worry me by saying so (Mrs B's capacity to speak to me about her perceptions, feelings, and fantasies in this way reflected the fact that a significant psychological shift had already begun to take place).

While this was occurring, I realised that it was me whom Mrs B had wanted to take to see a doctor, not her older child. I recognised that the interpretation that I had given earlier in the hour about her self-doubt had been considerably off the mark, and that the anxiety about which the patient was trying to tell me was her fear that something catastrophic was occurring between us (that would kill one or both of us) and that a third person (an absent father) must be found to prevent the disaster from occurring. I had often moved in my chair during Mrs B's hours, but it was only at the moment described above that the noise of my movement became an 'analytic object' (a carrier of intersubjectively-generated analytic meaning) that had not previously existed. My own and the patient's capacity to think as separate individuals had been co-opted by the intensity of the shared unconscious fantasy/somatic delusion in which we were both enmeshed. The unconscious fantasy reflected an important, highly-conflicted set of Mrs B's unconscious internal object relationships, which were being created anew in the analysis in the form of my somatic delusion in conjunction with her delusional fears (about my body) and her own sensory experiences (e.g. her hand-wringing).

I told Mrs B that I felt that not only was she afraid that I was dying, but that she was also afraid that she was the direct and immediate cause. I said that just as she had worried that she was having a damaging effect on her son and had taken him to a doctor, so she was afraid that she was making me so ill that I would die. At this point, Mr B's hand-wringing and finger-tugging subsided. I realised then, as Mrs B began to use hand movements as an accompaniment to her verbal expression, that I could not recall ever having seen her hands operate separately (i.e. neither touching one another, nor moving in a rigid, awkward way). The patient said that what we were talking about felt true to her in an important way, but she was worried that she would forget everything that had happened in our meeting that day.

Mrs B's last comment reminded me of my own inability to remember her first name and my fantasy of being a mother unwilling to acknowledge fully the birth of her baby (by not giving it a name). I now felt that the ambivalence represented by my own act of forgetting and the associated fantasy (as well as Mrs B's ambivalence, represented in her anxiety that she would obliterate all memory of this meeting) reflected a fear, jointly held by Mrs B and myself, that allowing her 'to be born' (i.e. to become genuinely alive and present) in the analysis would pose a serious danger to both of us. I felt that we had created an unconscious fantasy (largely generated in the form of bodily experience) that her coming to life (her birth) in the analysis would make me ill and could possibly kill me. For both our sakes, it was important that we make every effort to prevent that birth (and death) from occurring.
I said to Mrs B that I thought I now understood a little better why she felt that, despite every effort on her part, she could not feel present here with me and had increasingly not been able to think of anything to say. I told her that I thought she was attempting to be invisible in her silence, as if she were not actually here and that she hoped that in so doing she would be less of a strain on me and keep me from becoming ill.

She responded that she was aware that she apologised to me continually and that at one point she had felt so fed up with herself that she felt, but did not say to me, that she was sorry that she had ever 'got into this thing' (the analysis) and wished she could 'erase it, make it never have happened'. She added that she thought that I would be better off too, and she imagined that I was sorry that I had ever agreed to work with her. She said that this was similar to a feeling that she had had for as long as she could remember. Although her mother repeatedly assured her that she had been thrilled to be pregnant with her and had looked forward to her birth, Mrs B felt convinced that she had 'been a mistake' and that her mother had not wanted to have children at all. Mrs B's mother had been in her late thirties and her father in his mid-forties when the patient was born; she was an only child and, as far as she knew, there were no other pregnancies. Mrs B told me that her parents were very 'devoted' people, and she therefore felt extremely unappreciative for saying so, but her parents' home did not feel to her to be a place for children. Her mother kept all the toys in—Mrs B's room so that her father, a 'serious academic', would not be disturbed as he read and listened to music in the evenings and on weekend afternoons.

Mrs B's behaviour in the analysis seemed to reflect an immense effort to behave 'like an adult' and not to make an emotional mess of 'my home' (the analysis) by stewing it with irrational or infantile thoughts, feelings, or behaviour. I was reminded of her comments in the opening meeting about the foreignness and sense of unreality that she felt in my office (feeling that she had stepped out of a Woody Allen film). Mrs B had unconsciously been torn between her need to get help from me and her fear that the very act of claiming a place for herself with me (in me) would deplete or kill me. I was able to understand my fantasy (and associated sensory experiences) of having a brain tumour as a reflection of an unconscious fantasy that the patient's very existence was a kind of growth that greedily, selfishlessly and destructively took up space that it had no business occupying.

Having told me about her feelings about her parents' home, Mrs B reiterated her concern that she would present an inaccurate picture of her parents (particularly her mother), leading me to see her mother in a way that did not accurately reflect the totality of who she was. However, the patient added that saying this felt more reflexive than real this time.

During these exchanges, for the first time in the analysis, I felt that there were two people in the room talking to one another. It seemed to me that not only was Mrs B able to think and talk more fully as a living human being, but that I also felt that I was thinking, feeling, and experiencing sensations in a way that had a quality of realness and spontaneity of which I had not previously been capable in this analysis. In retrospect, my analytic work with Mrs B to this point had sometimes felt to me to involve an excessively dutiful identification with my own analyst (the 'old man'). I had not only used phrases that he had regularly used, but also at times spoke with an intonation that I associated with him. It was only after the shift in the analysis just described that I fully recognised this. My experience in the phase of analytic work being discussed had 'compelled me' to experience the unconscious fantasy that the full realisation of myself as an analyst could occur only at the cost of the death of another part of myself (the death of an internal object analyst/father). The feelings of comfort, resentment and anxiety associated with my fantasy of being an old man reflected both the safety that I felt in being like (with) my analyst/father and the wish to be free of him (in fantasy, to kill him). The latter wish carried with it the fear that I would die in the process. The experience with Mrs B, including the act of putting my thoughts, feelings and sensations into words, constituted a particular form of separation and mourning of which I had not been capable up to that point.

**CONCLUDING COMMENTS ON THE CONCEPT OF THE ANALYTIC THIRD**

In closing, I will attempt to bring together a number of ideas about the notion of the analytic third that have been developed either explicitly or implicitly in the course of the two foregoing clinical discussions.
The analytic process reflects the interplay of three subjectivities: that of the analyst, of the analysand, and of the analytic third. The analytic third is a creation of the analyst and analysand, and at the same time the analyst and analysand (qua analyst and analysand) are created by the analytic third (there is no analyst, no analysand, and no analysis in the absence of the third).

As the analytic third is experienced by analyst and analysand in the context of his or her own personality system, personal history, psychosomatic make-up, etc. the experience of the third (although jointly created) is not identical for each participant. Moreover, the analytic third is an asymmetrical construction because it is generated in the context of the analytic setting, which is powerfully defined by the relationship of roles of analyst and analysand. As a result, the unconscious experience of the analysand is privileged in a specific way, i.e. it is the past and present experience of the analysand that is taken by the analytic pair as the principal (although not exclusive) subject of the analytic discourse. The analyst's experience in and of the analytic third is, primarily, utilised as a vehicle for the understanding of the conscious and unconscious experience of the analysand (the analyst and analysand are not engaged in a democratic process of mutual analysis).

The concept of the analytic third provides a framework of ideas about the interdependence of subject and object, of transference–countertransference, that assists the analyst in his efforts to attend closely to, and think clearly about, the myriad of intersubjective clinical facts he encounters, whether they be the apparently self-absorbed ramblings of his mind, bodily sensations that seemingly have nothing to do with the analysand, or any other ‘analytic object’ intersubjectively generated by the analytic pair.

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