

Comments on Transference and Countertransference in the Initial Analytic Meeting

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*We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time.*

T.S. Eliot, "Little Gidding"

PSYCHOANALYTIC CONCEPTS AND TECHNIQUES, in order to retain their vitality, must again and again be discovered by the analyst as if for the first time. The analyst must allow himself to be freshly surprised by the ideas and phenomena that he takes most for granted. For example, he must be able to allow himself to be genuinely caught off guard by the pervasiveness of the influence of the unconscious mind, by the power of the transference, and by the intransigence of resistance, and only retrospectively apply the familiar names to these freshly rediscovered phenomena. If the analyst allows himself perpetually to be the beginner that he is, it is sometimes possible to learn about that which he thought he already knew. The present paper is a collection of thoughts addressed to myself (and other novices) on

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the subject of the opening of the analytic drama with particular reference to the transference and countertransference. I make no attempt to be exhaustive, since the topic touches upon almost every aspect of psychoanalytic theory and technique. My starting point for a discussion of the first analytic meeting is the idea that there is no difference between the analytic process in the first meeting and the analytic process in any other analytic meeting: the analyst in the initial meeting is no more or less an analyst, the analysand is no more or less an analysand, the analysis is no more or less an analysis than in any other meeting.

Creating Analytic Significance

Everything the analyst does in the first face-to-face analytic session is intended as an invitation to the patient to consider the meaning of his experience. All that has been most obvious to the patient will no longer be treated as self-evident; rather, the familiar is to be wondered about, to be puzzled over, to be newly created in the analytic setting. The patient's thoughts and feelings, his past and present, have new significance, and therefore the patient himself takes on a form of significance he has never held before. There is a particular form of significance generated in the analytic context that is unique to that setting. For the analysand, the consulting room is a profoundly quiet place as he realizes that he must find a voice with which to tell his story. This voice is the sound of his thoughts, which he may never have heard before. (The analysand may find he does not have a voice that feels like his own. This discovery may then serve as the starting point of the analysis.)

The analyst speaks and refrains from speaking in a way that communicates the fact that he accepts the patient as he is without judgment, and yet it is at the same time understood by both patient and analyst that they are meeting together for the purpose of psychological change. The analyst attempts to understand why the patient is as he is and cannot change and yet implicitly asks the

patient to give up his illness sufficiently to make use of the analysis. For example, the schizoid patient must enter into a relationship with the analyst in order to overcome his terror of even the most minimal involvement with other people; the obsessional patient in order to get help with his endless ruminations must give up his ruminations sufficiently to enter into an analytic dialogue; the hysterical patient must interrupt the drama that constitutes (and substitutes for) his life long enough to become an observer in addition to being an actor in it.

The analyst is the object of the patient's transference feelings even before his first meeting. In addition to viewing the analyst as a person trained to understand and (through some as yet unknown process) help the patient find relief from psychic pain, the analyst is also experienced as the healing mother, the childhood transitional object, the wished-for oedipal mother and father, and so on. With these hopes comes fear of disappointment.

Just as the patient has a (fantasied) analyst before the first session, the analyst also has a patient (more accurately, he has many patients) in his own mind prior to the initial meeting. In other words, prior to meeting the patient, the analyst has drawn upon such particulars as the sound of the patient's voice on the telephone, the source of the referral, the analyst's relationships with his current patients, as sources of conscious and unconscious feelings about the patient that he will bring to the first analytic meeting. In addition, there is regularly a feeling of suspense connected with the anticipation of the initial interview. Both patient and analyst are about to enter into an interpersonal drama for which many scripts are already written (the analyst's and the patient's internal dramas), and yet if the work is to be productive, a drama never before imagined by either will have to be created. Along with the sense of excitement, there is also an edge of anxiety. To a large extent the danger posed by the first meeting arises from the prospect of a fresh encounter with one's own inner world and the internal world of another person. It is always dangerous business to stir up the depths of the unconscious mind. This anxiety is regularly misrecognized by therapists early in

practice. It is treated as if it were a fear that the patient will leave treatment; in fact the therapist is afraid that the patient will stay.

A patient recently described with unusual clarity a fragment of her train of thought prior to the first meeting: "How much should I say in the beginning about the things about which I am most afraid and ashamed? How should I phrase it? I don't want him to think I am so crazy, so deceitful, so selfish, so seductive that working with me will be experienced as so unpleasant that he will soon find some excuse for getting rid of me. Is the humiliation of revealing myself in this way worth it? Did I make a mistake in deciding to see him? He was disappointing to me when I spoke to him on the phone. I wish he were older, more like a grandfather. He sounded a little crazy: he didn't seem to know his own address. His office is in a kind of decrepit neighborhood. I wonder if he's having trouble in his practice."

When a patient phones inquiring about working with me in therapy or analysis, I suggest to the patient that we find a time to meet for a consultation. I intentionally use the word *consultation* in order to make it clear that this meeting will not necessarily be the beginning of ongoing work together (despite the fact that I intend it to be an analytic experience regardless of what the outcome of the meeting might be). I do this because I cannot know ahead of time whether, after talking with the patient, I will feel that I can be of help to him and will want to work with him. Among the multiplicity of factors that go into making this determination is the question of whether I feel that I generally like the patient and feel some concern for and interest in him.

It is important that the analyst attempt in part to organize his thinking diagnostically. However, with a few exceptions (e.g., drug- or alcohol-addicted patients, violently acting-out sociopaths, severely organically damaged patients), I am generally open to working analytically with patients suffering from a wide range of psychological disturbances (cf. Boyer & Giovacchini, 1980; Ogden, 1982, 1986). However, it seems to me that one is claiming too much if one claims to be able to work with any patient who is interested in analysis. I believe we do a patient a disservice if we

agree to work with someone when we are aware of not liking him. It is sometimes said that the analyst ought to be able to analyze his negative countertransference and therefore should be able to work with any patient who is otherwise suitable for analytic work. In theory this may be true; in practice, however, I believe that the analytic task is difficult enough without attempting to build the analytic edifice upon a foundation of a powerful negative countertransference (or an intense negative transference). In my experience, this is so whether or not the analyst (or the patient) recognizes these transferences to be irrational. This caveat has seemed to me equally applicable to instances in which there are from the beginning very intense erotic transferences or countertransferences.

On the other hand, when speaking with a patient, I do not refer to the initial meetings as an "evaluation period" or "assessment phase" since these designations seem to me to convey the idea that the patient is to be relatively passive in this enterprise. Such terms would misrepresent my understanding that the function of the first meeting centrally involves the initiation of the analytic process. The nature of the interaction of the first meeting is not simply that of one person evaluating another or even of two people evaluating one another. Rather, it is in my mind an interaction in which two people attempt to generate analytic significance, including an understanding of the meanings of the decision-making process that is involved in the initial meetings. It is my intention in the initial meeting to facilitate the creation of an interaction that will constitute an analytic experience that will be of some value to the patient in providing him with a sense of what it means to be in analysis.

Despite the fact that transference anxiety is extremely high in the period leading to the initial interview, I do not view it as the analyst's job to put the patient at ease in the first meeting. On the contrary, I believe it is his task to help the patient not miss an important opportunity to recognize and understand something about the transference thoughts, feelings, and sensations with which he has been struggling.

Sustaining Psychological Strain in the Analytic Setting

As with all other meetings, the initial analytic hour begins in the waiting room. The patient is addressed as Dr., Mr., or Ms. and the analyst introduces himself in kind. The paradox inherent in this formal introduction is not lost to the patient: the analytic relationship is one of the most formal and at the same time one of the most intimate of human relationships. The formality reflects respect for the analysand and for the analytic process. In addition, it is an expression of the fact that the analyst is not pretending to be, nor does he aspire to be, the analysand's friend. (We do not pay our friends to talk to us.) It is clear from the outset that the intimacy of the analytic relationship will be an intimacy in the context of formality.

Therapists early in their training often feel the impulse to "put the patient at ease" or "to act human" as they walk with the patient from the waiting room to the consulting room. For instance, a therapist attempting to ease the tension of the walk to the consulting room said, "I hope you didn't have trouble finding a parking space. Parking is awful around here." To make such a comment is not a kind thing to do in terms of the analytic process. In fact, from the perspective being discussed here, this therapist has been rather unkind in several ways. First, he has communicated to the patient his unconscious feeling that the patient is an infant who has trouble making his way in a hostile world and that the therapist feels guiltily responsible for not making the patient's life less difficult. Such a comment immediately puts the patient into the analyst's debt and puts pressure on him to return the "kindness," i.e., to help the analyst avoid feelings of discomfort. There is also a hint in the therapist's comment that he is not confident that the therapy he will offer the patient is worth the trouble to which the patient is going.

Further, this sort of comment is an act of theft: it robs the patient of the opportunity to introduce himself to the analyst in a way he consciously and unconsciously chooses. The patient has available to him an infinite number of ways of beginning the

analytic discourse. His choice of the way he will go about doing this will be repeated by no other analysand. One must not deprive him of his opportunity to write the opening lines of his own analytic drama by burdening him with the analyst's unconscious contents before he even sets foot in the consulting room. (There will be plenty of time for that later, as the analyst inevitably becomes an unwitting actor in the patient's unconscious fantasies.)

Finally, a comment of the type being discussed misleads the patient about the nature of the analytic experience. As analysts, we do not intend to relieve anxiety (our own or the patient's) through tension-reducing activity, reassurances, gift-giving, or the like. Since maintaining psychological strain is not only something we demand of ourselves but is also part of what we ask of the patient, it makes no sense to begin the analytic relationship with an effort at dissipating psychological strain. Whether the incident is ever spoken of again, the analysand unconsciously registers the fact that the analyst has granted himself license to handle his own anxiety by means of countertransference acting in.

The patient brings to the first interview many questions and worries (usually unspoken) about what it means to be in analysis, what it means to be an analyst, and what it means to be an analysand. The analyst's attempts at answering these questions in the form of explanations of free association, the use of the couch, frequency of meetings, differences between psychotherapy and psychoanalysis, differences between "schools of psychoanalysis," and so on, are not only futile, they invariably limit the patient's opportunity to present himself to the analyst in his own terms. As is illustrated by the following clinical vignette, the analyst's most eloquent explanation of what it means to be "in analysis" is to conduct himself as an analyst.

Mr. H, a 42-year-old television producer, explained in the initial session that he had come to see me because he felt intensely anxious and had "obsessional ideas" about dying, including fears of suffocating in his sleep and of being trapped and killed during an earthquake. The patient was preoccupied by the thought that his six-year-old daughter, who was mildly hearing-impaired,

would “not be able to make it in the world.” He said that he knew that each of his fears was overblown, but this knowledge did not diminish the intensity of his anxiety.

The patient said that he had been fearful from the time that he was a small child. Mr. H’s father, a college professor, was continually dissatisfied with the patient and insisted on “helping him” with his homework each night. This inevitably ended with the father’s shrieking at the patient for his “incredible stupidity.”

Mr. H told me that his success at work seemed unreal to him. He felt as if he had to be continually preparing for the day when he would no longer be able to function. As a result, he hoarded every penny he earned. He gave several examples of feeling dangerously depleted when he spent money. I then said that it seemed that he was suggesting that the idea of paying for analysis would be frightening because it would mean giving up one of the few sources of protection he felt he had. Mr. H smiled and said he had thought a great deal about this and the prospect of paying for analysis felt to him like a blood-letting in which there would be a race between his “cure” and his bleeding to death.

When I met Mr. H in the waiting room for our second meeting, he was perspiring and seemed to have been awaiting me like a man anxiously awaiting some terribly important piece of news, perhaps a verdict. Immediately upon entering my consulting room, he walked briskly across the room and reached for the phone, saying, “I locked my keys in the car and so if it’s all right, I’d like to call my wife to ask her to meet me here with a spare set of keys after our meeting.” I said I thought it must seem to him as if his life depended on his making the phone call, but I thought he and I should talk about what it was that was happening between us before attempting to undo it. He sat down and said, “Actually, what just happened is kind of typical of me. I had my lunch in the back seat of the car, and there was a sign in the parking garage that said, ‘Leave keys in car.’ I felt uneasy about leaving my lunch in an unlocked car. I had the thought that somebody might tamper with my lunch, and so I didn’t want to leave the car unlocked.”

I said to Mr. H that without realizing it he seemed to have done both things: he had locked his lunch in the car so it would not be tampered with and had left his keys in the car as the sign had directed. He told me he had become very panicky when he realized his keys were locked in his car and immediately thought of calling his wife from my office. He said he felt greatly relieved by this idea. I repeated his realization that he had thought of me as well as his wife at that moment. He said that was so, but he had thought of me earlier when he saw the sign, which somehow seemed to have been put there by me.

Mr. H explained that the request to use my phone was also characteristic of him. He is almost always afraid that people are angry at him and regularly reassures himself that people do like him by asking small favors of them. For example, he frequently borrows change or a pencil from colleagues at work, or he asks directions to a place when he already knows perfectly well how to get there.

He told me he was certain I already thought he was a real jerk. (I assumed there was a wish as well as a fear underlying this feeling, but I did not interrupt the patient at this point since he was in the midst of introducing me to the cast of characters constituting his internal object world.) Mr. H went on to tell me more about his parents. His father had died ten years ago, but had lived his entire life as if he were at death's door. He had suffered from renal disease originating in childhood and was preoccupied with the fear of death. The patient said that he had been frightened that his father would die when he was yelling at the patient. Mr. H told me that his father could at times be very kind and that the patient had loved him despite the fact that he had been frightened of him so much of the time.

I asked if the patient had expected that I would yell at him for locking his keys in the car and for asking to use my phone. He said he thought he had had that feeling in a diffuse sort of way, but had not quite known why he was feeling so frightened while waiting in my waiting room. (It occurred to me that the patient may have

been attempting to call his wife in an effort to get her to protect him from me[as his mother had protected him from his father] and to protect me from him.)

In the course of the analytic work that followed, many layers of meaning of this transference enactment (referred to by Mr. H as the “telephone caper”) came to light, including the patient’s wish to be treated as a helpless little boy, thus defending himself against his feelings of being a powerfully destructive person who had done great harm to his father and who would do harm to me. A second aspect of this transference enactment involved the wish to provoke me into acting in a manner similar to his father, wherein I would yell at him for his stupidity. In part, he was afraid I would act in that way and was attempting to reassure himself that I would not. Then too, he found sensual pleasure in such intense scoldings. In addition, he felt relief in being punished since this is what he unconsciously felt he deserved for the crime he imagined he had committed in relation to his father (i.e., provoking him to the point that he had made him sick and ultimately had killed him). Further, he felt that his father demonstrated love for him in the father’s intense, controlling involvement. The patient unconsciously hoped to elicit from me this form of love in the anticipated scolding. Over the course of the analysis, the “telephone caper” served again and again as a symbol of the analytic process.

Cautionary Tales

In the initial interview I am listening from the outset for the patient’s “cautionary tales,” i.e., the patient’s unconscious explanations of why he feels the analysis is a dangerous undertaking and his reasons for feeling the analysis is certain to fail.¹ To say

¹Ella Freeman Sharpe (1943) used the term *cautionary tale* to refer to fantasies serving the purpose of instinctual impulse control by means of unconscious self-warnings of bodily destruction. In this paper, I have used the term to refer to a more circumscribed and differently conceptualized set of fantasies: the patient’s unconscious set of fantasies concerning the dangers of entering into the analytic relationship (McKee, personal communication, 1969).

this is to say nothing more than that I am listening for (and attempting to put into words for myself and for the patient) the leading edge of transference anxiety in the hour. Whatever the nature of the analysand's disturbances, his anxieties will be given form in terms of the danger of entering into a relationship with the analyst. The patient unconsciously holds a fierce conviction (which he has no way of articulating) that his infantile and early childhood experience has taught him about the specific ways in which each of his object relationships will inevitably become painful, disappointing, overstimulating, annihilating, unreliable, suffocating, overly sexualized, etc. There is no reason for him to believe that the relationship into which he is about to enter will be any different. In this belief the analysand is of course both correct and incorrect. He is correct in the sense that, transferentially, his internal object world will inevitably become a living intersubjective drama on the analytic stage. He is incorrect to the extent that the analytic context will not be identical to the original psychological-interpersonal context within which his internal object world was created i.e., the context of infantile and childhood fantasy and object relations.

Everything the analysand says (and does not say) in the first hours can be heard in the light of an unconscious warning to the analyst concerning the reasons why neither the analyst nor the patient should enter into this doomed and dangerous relationship. It must be emphasized that the patient feels that the analysis will endanger the analyst as well as himself and that it is in large part in an effort to protect the analyst that the patient balks at entering the relationship. The analyst, from this perspective, serves as the container for the patient's fears about beginning this relationship as well as for the analysand's hopes that internal change is possible and that pathological attachments to internal objects can be altered without sacrificing the life of the patient. The following account of an initial analytic meeting is an illustration of the way in which the patient often unconsciously attempts to symbolize for himself and for the analyst the dangers he anticipates.

Mr. J began his first meeting by describing his empty relation-

ship with his wife and children, the boredom he felt at work, and the lack of joy he felt in his life in general. He said he had been referred to me by his internist, who thought analysis would be of benefit to him. Despite Mr. J's presentation of his feelings of desolation, I suspected that there were pleasures in his life that he felt he must keep secret both from himself and from me. I had the fantasy that Mr. J was having an affair – perhaps with a woman, perhaps with music, art, or some other “passionate interest,” perhaps with a memory of a childhood romance. This fantasy was not the product of intuition, but a response to something about the patient's presentation of himself. In retrospect, it is easier to see that this had been communicated by his choice of words, by the rhythm of his speech, by his gait, his facial expressions, etc. He behaved like a man with a secret. I surmised (but did not say to Mr. J) that he unconsciously seemed to feel that analysis would contain forms of pleasure that he would have to keep well hidden, and I anticipated that as a result analysis would have a rather arid feeling to it (both for him and for me) for quite a long time.

The patient said he felt convinced that he needed treatment and he knew his wife and children would benefit if he were to get help. Nonetheless, he felt extremely guilty about spending money on analysis which could be spent in buying things his whole family could enjoy. I said, after some time had elapsed in the first hour, that the patient seemed to feel that to begin analysis would be equivalent to having an affair. He told me how devoted he was to his wife and that he had never considered the idea of really having an affair. However, he said, it was strange that I had said what I had because earlier that week for the first time he had heard himself making a comment to his secretary that was sufficiently ambiguous to have been construed as a proposition. She chose not to directly respond to the ambiguously proposed affair. He said that he had felt quite disturbed by this episode and had left work early for the first time in years.

In this instance, I elected to interpret an aspect of what I understood to be the leading transference anxiety (i.e., the most accessible unconscious/preconscious set of transference and resis-

tance meanings). The internal drama the patient seemed to be bringing to the analytic relationship was one in which there was an anticipation of passionate attachment and intense secretiveness. It was within this area of experience (the “affair”) that I suspected Mr. J was afraid that analysis would become extremely painful and perhaps become impossible to continue. In the course of the succeeding several years of analysis the patient was able to make sense of these feelings in terms of a relationship that he had had with a nanny whom he had loved deeply, a love he unconsciously felt he had to keep secret from his mother. His feelings of anger and guilt, as well as fears of becoming involved in similar impossible entanglements, had led to his developing a character defense in which he remained rather detached in all sectors of his life. The idea that he was “only going through the motions” served important defensive functions in the initial stages of his analysis.

The Timing of Transference Interpretations

As a result of my interest in ideas deriving from the British psychoanalytic dialogue, I have often been asked if it is true that Kleinians interpret the transference from the very beginning of the analysis. The question is always a puzzling one to me. It hardly seems surprising that one would attempt to talk with the patient about what it is about this new relationship (the analytic relationship) that is so frightening, exciting, disappointing, futile, etc. Generally, the initial session does not feel complete to me unless the patient’s anxiety in the transference has in some way been addressed. One does not have to be a Kleinian to talk with one’s patient about one’s current (and always tentative) understanding of what it is that is disturbing to the analysand about the initial meeting.²

²At the same time, clinical judgment must guide the analyst in every therapeutic situation. There are many instances in which the analyst senses that it is critical he not be too “clever” (Winnicott, 1969, p. 86) or know too much, and therefore chooses to refrain from offering even the most tentative versions of what he thinks he understands (cf. Balint, 1968; Winnicott, 1969, 1971).

The following is an illustration of a situation in which there was countertransference resistance to discussing transference anxiety in the initial meeting.

A 32-year-old man made a phone call to a therapist for the purpose of setting up a consultation. He told her in the course of asking her for an appointment that he felt in danger of getting into disputes that would end up in his punching someone. Mr. N said that he is a large man, that he speaks in a booming voice, and that people are often frightened by him even when he is not angry. He said that, despite all this, he hoped the therapist would not be afraid of him since he was not a dangerous person and had never attacked anybody.

When Mr. N appeared for his initial meeting, the therapist was surprised to find him a man of average build who spoke in a pressured but not a loud or bullying manner. She learned that Mr. N was a successful owner of a retail business. He was born to a psychotic mother and had been placed in a foster home just before his first birthday. Mr. N had seen neither his mother nor his father since that time. After a succession of five foster-home placements in a five-year period, he was finally adopted by a couple with whom he lived until he left at 18 to join the Army. In the course of his latency and adolescence, the patient's adoptive parents became alcoholics.

The therapist (who had only recently completed her training) did not discuss with the patient his implicit, ambivalent warning that she would be well advised to have nothing to do with him. There seems to have been an unconscious sense on the part of the therapist that talking to Mr. N about his fear of his destructiveness would make him more dangerous to her. There was also a denial of her own fear of the patient that left her unable to think about his warning. (Other therapists might have refused even to meet with this patient, thus engaging in a countertransference enactment of the patient's experience of himself as a danger to both his internal and external objects. The patient after all had already, from the perspective of his unconscious psychic reality, caused his original mother to become psychotic, leading her to abandon him,

had been so unlovable and perhaps dangerous as to have caused five sets of foster parents to refuse to keep him, and had driven his adoptive parents to alcoholism.)

The patient came to his next four weekly meetings in an increasingly agitated state. Several days after the fifth meeting, he phoned the therapist saying that he had felt more and more anxious after each of his meeting with her and that it had become unbearable. He had therefore decided to discontinue therapy. The therapist suggested that Mr. N come to his next meeting in order to talk about these feelings.

It was at this point that the therapist sought consultation on the case. I suggested that the patient had indicated from the very outset that he was terrified that his anger (particularly in the maternal transference) would frighten and damage the therapist. The therapist's unconscious fear of the patient had led her to suggest once-weekly meetings with Mr. N despite indirect indications from him that he felt he needed and could afford more intensive therapy. The therapist's unconscious decision to seek a safe distance from the patient had confirmed the patient's belief that she would (with good reason) find him dangerous and would eventually refuse to see him. It seemed to me that Mr. N had telephoned the therapist in order to see whether she had been injured in the previous meeting and that he had been temporarily reassured by her asking him to come to his next meeting. I hypothesized that Mr. N was in a rage at his (internal object) mother for being crazy and unable to love him and for having abandoned him as well as terrified that it was his anger that had driven his mother crazy and had led her to abandon him.

Mr. N began the meeting that followed the telephone call by asking the therapist, "How are you?" as they walked from the waiting room to the consulting room. Once in the consulting room, he said that his heart was pounding. The therapist suggested that Mr. N was worried that he had scared or perhaps hurt her in the previous meeting and that this had been a concern of his from the very beginning. The patient calmed down considerably after this interpretation. The therapist later in the meeting suggested

that since the patient felt such intense anxiety in response to each meeting, it might be useful to meet more frequently in order to discuss what it was that was frightening him. To her surprise, Mr. N seemed receptive to this idea. In a sense, the beginning of the analytic dialogue had been postponed for six or seven meetings largely as a result of unanalyzed anxiety in the countertransference which had led to an inability to think about or interpret the patient's transference anxiety.

Analytic Space

Entry into the analytic experience (beginning in the initial interview) involves the enlargement of the psychological space constituting the "matrix of the mind" (Ogden, 1986) in such a way that this space more or less comes to approximate the analytic space, i.e., the analytic space becomes the space in which the patient thinks, feels, and lives. In a subtle way, the events making up the patient's experience in relation to his internal and external objects, the events making up his daily life, and his responses to these events come to be important to him insofar as they contribute to the analytic experience. Eventually, it is to a large degree the analytic space and not the analysand's individual psychological space in which the unconscious internal drama is experienced. The evolution of this process includes, but is by no means limited to, what is usually referred to as the elaboration of the transference neurosis and the transference psychosis.³

That which constitutes analytic space is individual to each analytic pair. Just as each mother learns (often to her surprise) that the process of creating a play space differs greatly with each

³The termination phase of an analysis is not simply a phase of resolution of conflicted unconscious transference meanings. Equally important, it is a period of the "contraction" of the analytic space such that the patient comes to experience himself as constituting the space within which he lives and within which the analytic process continues. If this does not occur, the prospect of the end of the analysis is experienced as tantamount to the loss of one's mind or the loss of the space in which one feels alive.

of her children, the analyst must learn that the process of creating analytic space is different with each analysand (Goldberg, 1989). In the same way that each infant's unique character draws upon and brings to life specific aspects of the mother's emotional potential, the analyst must allow himself to be created/molded by his patient in reality as well as in fantasy. Since the infant has a role in creating his mother, no two infants ever have the same mother. Similarly, no two patients ever have the same analyst. The analyst experiences himself and behaves in a subtly different manner in each analysis. Moreover, this is not at all a static phenomenon: in the course of each analysis the analyst undergoes psychological change, which in turn is reflected in the way he conducts the analysis.

More seriously disturbed patients experience the analytic space as a vacuum which threatens to suck out of them their mental contents (which are concretely experienced as bodily parts or contents). One such patient began the first meeting by barraging me with an uninterrupted series of obscenities. Taken aback by the onslaught, I decided to allow the patient to have his say and to observe the impact he was having on me. It was apparent that his barrage was far more anxious than hostile. After about five minutes, I said to him that I thought it was not easy for him to be here with me. He quieted down as I said this. I then told him that I thought he had emptied his garbage into me because he did not mind giving up a part of himself that he did not value. I said that I guessed he had more important things inside of him that he felt he needed to protect. Following this intervention, the patient was able to tell me more about himself, albeit in a psychotic way. I in turn discussed with him the little bit of what I thought I understood of what he was telling me. Almost all of what I said was addressed to the patient's fears about being with me.

Anxious Questioning

Analysands often pose direct questions in the initial meeting. A few of these I answer directly. For example, I will in a "matter-

of-course" way (Freud, 1913, p. 131) answer the patient's questions about my training or my fee. Most questions, however, I do not answer, including questions about whether I have a particular specialty, with which "school of psychoanalysis" I am associated, whether I see more men than women in my practice, whether I consider homosexuality to be an illness, etc. These sorts of questions I treat as fairly undisguised statements of the patient's fantasies about the specific ways in which I will fail to understand him due to my own psychological difficulties, e.g., my fear of women or men, my fear of homosexuality or heterosexuality, my need to dominate or submit to others, and so forth.

When a patient persistently asks questions after question, I often say to him that it must feel too dangerous to wait to see what happens between us; that, instead, the patient hopes he will be able to sample the future through the answers to his questions, thereby short-circuiting the tension connected with waiting.

Very often the analysand uses questions in an attempt to get the analyst to fill the analytic space because the patient feels that his own internal contents are shameful, dangerous, worthless, in need of protection from the analyst, etc. or that there is nothing at all inside of him with which to occupy the analytic space. Other patients may quickly fall silent, thus inviting the analyst to fill the space with his (the analyst's) questions and therefore with the analyst's psychological organization, chain of associations, curiosity, and the like. Under such circumstances, I attempt to talk with the patient about the aspect of the patient's anxiety that I think I understand. In so doing, I make it clear that my understanding is tentative, and in all likelihood, quite inadequate in many ways. I thus invite the patient to tell me which parts of what I have said seem true to him and which parts seem off the mark.

Creating a History

The question often arises of whether one "takes a history" in the initial meeting. The very form of the question seems to me to have

significance. I attempt not to “take” a history from a patient (by means of a series of questions), and instead make every effort to allow the patient to give me his conscious and unconscious versions of his history in his own way.⁴ The patient has come to see the analyst for help with psychological pain, the nature of which the patient is often unable to accurately name. He must be afforded all the time and room he needs to tell the analyst, in whatever way he has available to him, what he knows about himself. It is important that the analyst not interfere with the patient’s efforts by introducing an agenda of his own, such as collecting historical data, making a treatment recommendation, or laying out the “ground rules” of analysis (cf. Freud, 1913; see also, Shapiro, 1984).

As the patient tells the analyst, however indirectly, about the nature of his pain (and the ways he consciously and/or unconsciously expects this pain to become exacerbated in the course of analysis), his past experience will be articulated in two ways. First, to the extent that the patient tells the analyst about his understanding of the origins of his difficulties, he will be giving the analyst one form of historical data, i.e., what the patient consciously conceives of as his past. Inevitably, there will be gaps, vaguenesses or complete omissions of large sectors of the patient’s life experience. For example, a patient may omit any reference to a given family member, make no mention of his sexual experience, not refer to any event occurring prior to the current crisis or prior to his adolescence. Under such circumstances, when I feel that the patient has told me what he wants to and what he is able to, I may ask him if he has noticed his not mentioning, for example, anything about his father. (This is essentially a process of ad-

⁴It is essential to keep in mind that a patient’s history is not a static entity that is gradually unearthed; rather it is an aspect of the patient’s conscious and unconscious conception of himself, which is in a continual state of evolution and flux. In a sense, the patient’s history is continually being created and re-created in the course of the analysis. Moreover, it is by no means to be assumed that the patient has a history (i.e., a sense of historicity) at the beginning of analysis. In other words, we cannot take for granted the idea that the patient has achieved a sense of continuity of self over time such that his past feels as if it is connected to his experience of himself in the present.

addressing the patient's relationship to his external and internal objects in terms of resistance, i.e., in terms of the patient's conscious and unconscious object-related anxiety.)

As with any comment addressing resistance, it is not the information "behind" the resistance that is of central concern; the focus is on what it is that the patient is afraid will happen if he tells the analyst about a given aspect of his internal life and the ways the patient has of protecting himself against this danger. Hence the act of "taking a history" (by means of direct inquiry) is a form of overriding resistances and thereby losing a good deal of what is most important to the analysis, for example, an understanding of who in the patient's internal object world would be betrayed, injured, killed, lost, made jealous, and so on, if the patient were to talk about his feelings about "the past"; or what sort of loss of control over the patient's relationships to his internal objects would be experienced in his giving up exclusive access to them.

The second form of personal history provided by the patient is data conveyed in the form of the transference-countertransference experience. This is the patient's "living past," i.e., the set of object relations established in infancy and early childhood which has come to constitute the structure of the patient's mind, both as content and context of his psychological life. It is therefore this past that is of central analytic interest.

Of course, the two forms of history under discussion, the consciously symbolized past and the unconscious living past, are intimately intertwined. As the patient's internal object world is given intersubjective life in the transference-countertransference, both patient and analyst have an opportunity to experience directly the forms of attachment, hostility, jealousy, envy, etc. constituting the patient's internal object world. In the transference-countertransference, the past and present converge as "old" contents are brought to life in a new context, i.e., the context of the analytic relationship.

It has been my experience that in the period surrounding (and including) the initial analytic meeting, the patient is in a "de-integrated" (as opposed to "dis-integrated") state that involves

unusual potential for psychological change. It is regularly the case that the external circumstances of the patient's life are not significantly different from what they had been six months, a year, or even several years earlier. (Of course, there are many exceptions to this observation.) What is different at the time the patient finally seeks analysis is the state of the patient's internal world. The defensive structure that the individual has been relying on is *temporarily* in a state of flux sufficient to allow him to unconsciously experience himself as having the potential to live differently, i.e., to make changes in his internal world so that he might come to experience himself and conduct himself in the world differently.⁵ It seems to me a shame to squander the unusual "ripeness" for psychological change associated with the patient's state of de-integration in the initial analytic meeting by conducting the meeting as a "history taking" session.

Concluding Comments

The ideas I have discussed in this paper are simply that—ideas. They are not intended to be used as rules or guidelines, nor are they intended as a statement of how the initial analytic meeting should be conducted. At the same time, the thoughts discussed here are thoughts of a specific nature—they are psychoanalytic thoughts. This represents one of the dialectics constituting psychoanalytic technique: analytic technique is guided by a set of ideas that are roughly recognizable as forming a method or group of methods, with a set of principles that gives coherence to this

⁵This state of "de-integration" (Fordham, 1977) associated with the initial analytic meeting might be compared with the experiential state of a married couple during the last trimester of the woman's pregnancy. Not only is each of the individuals comprising the couple in a period of de-integration of his/her personal identity (as a man/woman, an adult/child, a son/daughter, father/mother, husband/wife), but also the couple is in a state of de-integration in preparation for the creation of a new set of relationships (internal and external) that is larger and more complex than that which had constituted the marriage to that point. In other words, they are consciously and unconsciously attempting to make room in their internal and external object worlds to become a family (cf. Brazelton, 1981).

group of methods. From the first meeting, analytic practice occurs between the poles of the predictable and the unpredictable, the disciplined and the spontaneous, the methodical and the intuitive.

The initial face-to-face analytic meeting is viewed as the beginning of the analytic process and not merely as a preparation for it. In the first meeting all that was familiar to the patient is no longer treated as self-evident. The analysand takes on a form of significance for himself that he has never held before. The analyst attempts to convey to the patient something of what it means to be in analysis, not by means of explanations of the analytic process, but by conducting himself as an analyst. To this end, psychological strain is not dissipated through reassurance, forms of acting in, suggestion, and so on. All that the patient says (and does not say) in the initial meeting is understood as an unconscious warning to the analyst (and to the patient) concerning the reasons why the patient unconsciously feels that each of them would be well advised not to enter into this doomed and dangerous relationship. The analyst attempts to understand the patient's warnings in terms of transference anxiety and resistance.

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