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## On Countertransference

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A 31-year old patient sits opposite me, her head bent. We sit in silence. She raises her head and stares at me with an evil light in her dark eyes, which at that moment look like the eyes of a madwoman. For a second I think I can feel something like a shiver running down my spine. This is the third time in the eighteen months of our analytic relationship. The first two times I only worked on myself, without putting anything into words. However, I had certainly communicated, at a pre-verbal and unintentional level, that I was perturbed. I had therefore informed her, through the primary language of the body, that I too was still struggling with a terrifying mother image that the patient was able to evoke in me. I had told her without words that I was really there with her and that I was sharing her feelings.

Communication through bodies and dialogue between facial expressions are made possible by the face-to-face setting. The couch would have made it difficult for the patient to express herself with a stare; even if she had turned round for a moment, I would have been able to conceal my countertransference. The blank-screen model allows the analyst to avoid offering his or her inner world to the inner world of the patient. The patient's witch eyes could have been kept out of the analysis, thereby missing an important opportunity for insight. In this way, it would have been possible to treat the terror and the hatred in the patient's mother fixation only indirectly and with many more sessions.

When the patient looks at me with that glint of hatred for the third time, a glint that

cannot hide an endless fear which makes me shiver, I tell her she is trying to frighten me. She doesn't reply. I say that she knows she has succeeded. She raises her eyes to me again but now her expression is one of apprehension. "Don't worry" I tell her, "fear isn't invincible". I feel good, in communication with her. I tell her I know her fear, a very human fear of being sucked back into the maelstrom of the past, of being annihilated, or of being carried off by someone flying through the air (I am referring to stories her grandmother used to tell her about a witch who flew with a cloth sack into which she put all the children she could catch).

The patient's transference is of hatred and fear of her hatred, as well as concern for the harm she can do me (the apprehension in her eyes). My countertransference is fear, not of the patient's hatred, but of her fear, of psychosis: that shiver! Qualitatively, our fears are similar. To clarify: my fear is not only empathic, caused that is, by my ability to identify with the patient; it cannot be entirely explained through the paradigm of the 'center-to-center' relationship (Fromm, 1960; Biancoli, 1995). I also have my own inner spurt of fear, stirred by the psychotic terror of the patient which is only slightly veiled by the hostile light, the glint of hatred, in her eyes. This fear of mine is countertransferential. I am aware of my fear caused by the patient's fear, but I think that when she looks at me like that, she is more aware of her hatred than her fear, of the veil of hatred in her eyes than the black depth of terror. She dissociates her hatred from her terror; at times she is conscious of hating, at others she is conscious of being afraid. I



invite her to integrate the two emotions and to realise that the hatred with which she wanted to frighten me feeds her fear. When we are passive we do not live, and a life not lived leads to a hatred that we project onto other people and external images of which we are then afraid.

Some believe we should distinguish the countertransference part of the analyst's overall feelings, the part that reacts to the patient's transference, from the transference part which emerges in the analyst only because the patient exists and is present (Racker, 1968). This distinction should also be made for the overall feelings of the patient, who experiences a transference only because the analyst exists, and a countertransference as a reaction to the analyst's transference. I believe that this distinction is an intellectual one that can only be made in theory, at an abstract level. Clinical activity, on the other hand, is very concrete and deals with experiences, not intellectual contents. In the example I have given it is the sequence of emotional events that is important: the patient expresses her hatred and wants to frighten the analyst, who in turn feels perturbed (countertransference); the patient is afraid she has harmed the analyst; the analyst reassures her and continues the verbal analytic dialogue.

Some may see an example of "projective identification" (Ogden, 1991) in the clinical case I have reported here. This mechanism has three phases: projection (the patient projects her fear onto me, staring at me with hostility); interpersonal pressure (the patient puts a significant pressure on me, insisting with her stare that cannot be avoided, so that I am forced to feel her

fear, so that her fear gets inside me); reinternalisation (hit by the patient's fear, I elaborate it, make it more bearable, less dangerous and give it back to her, tamed, and she reinternalises it thus transformed and reduced). This mechanism of projective identification also seems too intellectual and automatic. Moreover, it presupposes a figure of the analyst that is too passive. In my example, I am more active, more operative, with both my qualities and defects: what I feel inside me as a reaction to the patient's provocation is my own fear, it is my countertransference, which I can, however, elaborate better than the patient because I have already been analysed and have more means. In this sense Fromm is right when he says that the countertransference is a "counterattitude" of the analyst.

In the case in question, I did not entirely succeed in following the "center-to-center" model because I came up against my limit, my counter-transference

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