Psychoanalytic Quarterly, LXXIV, 2005

CLINICAL CONVERSATIONS BETWEEN PSYCHOANALYSIS AND IMAGINATIVE LITERATURE

BY FRED L. GRIFFIN, M.D.

A literary form created by an imaginative writer captures something of the way the author shapes emotional experience and psychologically engages with it. The manner in which experience is created and contained in an imaginative literary text has much in common with the way experience is generated and worked with in the psychoanalytic situation.

The author describes a clinical experience in which there was a collapse of the analytic (imaginative) space. He then discusses how he made use of a "conversation" he created with a short story and his own analytic experience to restore his imaginative capacities and to resume psychological work with the patient.

> Writing poetry goes into the psychological complexion of our lives . . . . In a dialectical method, which literature implies, we can experiment without causing much harm except to ourselves critically. If you propose a dialectical experiment, it may reach places in the individual's life . . . which may have an effect of freeing him from being caught in psychological impasses. It is very necessary to free the individual, as the growth of psychiatry has demonstrated to us. We are caught sometimes in impasses in our intellectual life, and if you can use a poem or a literary construction to free you from some implied impasse in your lives . . . because it breaks through, it gives you a chance to experiment with yourself.
>
> —William Carlos Williams (1955a)

INTRODUCTION

In the course of the past several decades, psychoanalysts have increasingly turned to their fantasies, reveries, and dreams in an effort to gain a sense of what is happening in the transference-countertransference experience. If the analytic space between analyst and analysand is severely compromised or collapsed, an analyst may consult a colleague to make use of the colleague's unique perspective and his or her capacity to imagine what is going on in an analytic experience. In doing so, the analyst hopes to achieve "binocular vision" (Bion 1962b, p. 86), i.e., a perceptual depth accomplished by viewing an emotional experience from multiple vertices.

Sometimes an analyst (without conscious intention) is able to use an original work of fiction to achieve similar results. The piece of imaginative literature to which the analyst finds him- or herself turning may generate a new emotional perspective from which he or she may achieve enhanced self-awareness and a greater understanding of the transference-countertransference. In certain of my clinical encounters in which the self-reflective analytic (imaginative) space has collapsed, I have been unable to think about, much less articulate, what I am experiencing in the depths of transference-countertransference.[1] In such cases, I have from time to time turned to a piece of imaginative literature in a way that has served to reestablish an imaginative space. I have then discovered that my engagement with the works of these creative writers has fueled generative fantasies, reveries, and even somatic sensations that assist

[1] It is my contention that, while analysts use the noun *transference-countertransference* to denote the unique experience that occurs between analyst and analysand, it is better thought of as an active, verblike experience—a *living form* of experience. This idea has its analog in Winnicott's (1971) emphasis on the *process* of playing, rather than a focus on the symbolic *content* of play. "Psychotherapy takes place in the overlap of two areas of playing, that of the patient and that of the therapist" (p. 38). "The psychoanalyst has been too busy using play content to look at the playing child, and to write about playing as *a thing in itself*. It is obvious that I am making a significant distinction between the meanings of the noun 'play' and the verbal noun 'playing'" (p. 40, italics added).

me in representing and articulating analytic experience. This restoration of an analytic space through my use of fiction seems to be a consequence of the effect on me of the manner in which the author creatively formulates emotional experience (which is captured in the form of the text).[2] My experience of the work of fiction facilitates my viewing the analytic experience from a new perspective.

The works that come to my mind in these circumstances often contain something of the set of feelings that are occurring between me and my patient. These imaginative constructions are "fictions" that symbolize—that re-present (or, more accurately, present anew)—the patient's emotional experience, just as the transference-countertransference itself is a type of fiction that tells us what the patient's internal object world *is like* as it is creating itself. The analytic process may be viewed as a form of new "writing" and "reading" of unconscious experience. In this sense, analysts have become creative writers and readers.

In instances where I have found works of literature useful to the conduct of my clinical work, there is no simple relationship between the experience captured in the work of fiction and that found in my experience with my patient. Rather, there is something in common between the unspoken language of the transference-countertransference and the way language is used by the imaginative writer in his or her work of fiction that brings these works to mind.

In what follows, I will present a case in which the analyst and patient are at an impasse. Rather than turning to the analysis of my own fantasies or dreams to resolve this impasse, I found myself—without conscious intention—turning to a story written by William Carlos Williams, in a way that allowed me to enter into a more enriching dialogue with myself, the patient, and the work of fiction.

[2] In this paper, I use the noun *form* and the gerund *forming* to refer both to the structuring of literary works by imaginative writers, and to the shaping of the transference-countertransference in the analytic situation. I will not offer definitions of these words. I ask the reader to gather a sense of what I mean by the ways that I use these terms throughout the paper.

UNFORMULATED FORCES IN THE ANALYTIC EXPERIENCE

> There's nothing like a difficult patient to show us ourselves . . . [in the face of] the force of all of those encounters. I was put off guard again and again and the result was—well, a descent into myself.
>
> —Williams (quoted in Coles 1984a, p. xiii)

In his eighth month of treatment, Mr. D had once again become alarmingly depressed, this time in response to the death of a woman friend in a car accident.[3] He had experienced a similarly desolate, immobilizing depression five months earlier at the anniversary of his father's death. Mr. D, now in his early forties, seemed not to have the capacity to mourn; rather, he himself became deadened: he was trapped in a seething internal world that was black and hopeless. While I had the beginnings of a psychoanalytic understanding of his depression, the patterning and depth of this and of earlier reported depressive episodes, and his telling me that his sister was being treated for "manic-depressive illness," suggested that Mr. D suffered from a bipolar disorder. I recommended a trial of antidepressant and mood-stabilizing medications. He soundly refused medication—a symbol of "Western medicine" that had failed his father, a civic leader, who had been disabled by a heart attack when Mr. D was seven years old: "I will not become a zombie!"

I felt helpless and frightened that Mr. D would kill himself. As he became more and more closed and withdrawn, his muted rage was all the more palpable to me. During this time in our work, I responded by force-feeding him a series of interpretations, as though his life depended upon them. While these were intended to address the unfolding content of the material, it is now clear that they were expressions of my desperate attempt to find a piece of meaning that he could take in. For example:

[3] During this phase of his work, Mr. D was seen twice weekly in psychoanalytic psychotherapy.

- It is understandable that you fear taking this medication, because none of the treatment that your father received could save him.
- It must be terrifying for you to take something into your body that you believe will hurt you. You not only feel misunderstood by me; it also seems to you that I intend to hurt you.
- To take medication is so much at odds with how you see yourself, how you think of yourself—it would be an assault on who you are. Taking medication makes you fear losing what little you feel you have left of yourself.
- If my sense of powerlessness to give you the medication that I think would be helpful to you is anything like the way you feel controlled by me, you must feel utterly helpless—and enraged.
- You are afraid that taking medication will turn you into a zombie—a walking dead person. This is one of your worst fears, because this is how you saw your father after he had his heart attack and his medical treatment.

Mr. D was completely unable to make use of these interpretations, and his depression worsened.

At this point, I was locked into a relationship with Mr. D in which I felt forced to feel and think in ways that were not quite my own. I had lost the capacity for reflective thinking and was unable to find an imaginative space within me where I could engage in the kind of self-analytic work that usually frees me from transference-countertransference impasse. And while I believed that his refusal to take medication offered him a modicum of control, I could sense that he did not have the capacity to engage with me in an exploration of the meaning of this refusal.

Desperate to find a way to understand this experience and to reach Mr. D, I turned first to works of a psychoanalytic writer, and finally to those of an imaginative writer.

I recalled the writings of Bion (1959) on projective identification. He discusses the analyst's containment of the patient's projective identification, through which it becomes "possible for him [the patient] to investigate his own feelings in a personality powerful

enough to contain them" (p. 313). Bion (1962a) describes what happens when containment fails:

> If the infant feels it is dying, it can arouse fears it is dying in the mother. A well-balanced mother can accept these and respond therapeutically: that is to say in a manner that makes the infant feel it is receiving its frightened personality back again, but in a *form* that it can tolerate . . . . If the mother cannot tolerate these projections the infant is reduced to continue projective identification, carried out with increasing force and frequency. The increased force seems to denude the projection of its penumbra of meaning. [p. 307, italics added]

Bion's words helped me by providing a conceptual model for what I was experiencing with Mr. D. However, I had not yet become capable of restoring an imaginative space within myself where I could reflect upon this transference-countertransference experience and then gain a sense of what it would be like to *be* Mr. D at this moment in his life.

At this time, I was aware that I felt "owned" by Mr. D or by some force that I could not explain. For example, once, when worrying about Mr. D outside of a session, I was gripped by the fantasy/visceral sensation that I would at any moment have a heart attack. As this sensation passed through me, I recalled that there were times in my early childhood when I feared that my father would die of a heart attack when he struggled to keep his place of business alive. I suspected that this memory had something to do with Mr. D's experience, but I could not reflect productively on the relationship between these elements of Mr. D's history and my own and how they informed our work together. I was lost (or, more accurately, imprisoned) in an experience in which I felt more like a figure in Mr. D's internal world than a viewer of it. So I "consulted" with someone, as it were, who would allow me to think and not to be owned.

As I attempted to gain an understanding of the experience between Mr. D and me, I found myself turning to a short story written by William Carlos Williams, a poet, imaginative writer, and physician.

I did not deliberately turn to Williams's story. It came to me only after Bion's model of containment had helped me begin to reopen the door to my self-analytic functioning. As a result, I found myself engaging in a fleeting reverie experience concerning one of my favorite Williams (1932a) stories, "The Use of Force," recalling what it felt like to read it. I then reread the story to see where it took me.

In Williams's story (likely a thinly disguised piece of autobiographical fiction), a physician, practicing in a poverty-stricken area of rural New Jersey, is making a house call at the request of parents who fear their daughter has contracted diphtheria. When the child refuses to be examined, a violent struggle ensues.

> The child was fairly eating me up with her cold steady eyes . . . an unusually attractive little thing . . . . I'm here to look at her throat on the chance that she might have diphtheria and possibly die of it . . . . Will you open it now by yourself or shall we have to open it for you? . . .
>
> . . . After all, I had already fallen in love with the savage brat . . . she surely rose to magnificent heights of insane fury of effort bred of her terror of me.
>
> . . . Don't, you're hurting me. Stop it! Stop it! You're killing me! . . .
>
> . . . But now I had grown furious—at a child. I tried to hold myself down but I couldn't . . .
>
> Get me a smooth-handled spoon . . . . We're going through with this . . . But I have seen at least two children lying dead in bed of neglect in such cases, and feeling that I must get a diagnosis now or never I went at it again . . . I too had gone beyond reason. I could have torn the child apart in my own fury and enjoyed it. It was a pleasure to attack her . . .
>
> The damn little brat must be protected from her own idiocy . . . But a blind fury, a feeling of adult shame, bred of a longing for muscular release are the operatives. One goes on to the end.
>
> In a final unreasoning assault I overpowered the child's neck and jaws . . . She had fought valiantly to keep me from knowing her secret.
>
> [Williams 1932a, pp. 56-60]

After I reread "The Use of Force," I was somehow better able to be reflective with regard to my experience with Mr. D and to explore dimensions of my experience with him in ways of which I had previously been incapable: My analytic and self-analytic capacities were stimulated, if not restored, by my immersion in the literary form that Williams had created. While later in this paper, I will discuss how my "consultation" (or better still, my "conversation") with this story may have stimulated my imaginative capacities, at the time, I knew only that it had led me toward an understanding of the *form of experience*—that of a life-and-death struggle—that was alive in the transference-countertransference between Mr. D and me.

Having achieved a creative space from which to explore this struggle, I simply told Mr. D, "I think I have been trying to *be* a pill that will save you." His taut face relaxed, and a hint of a smile passed through it. Because he felt that he was being understood (Steiner 1993), we were able to engage in an exploration of the meaning of his refusal to take medication. As I recognized my own fear, helplessness, and rage in conjunction with my frustrated omnipotent attempts to save him, and as he became aware of his conflicted wishes to have me do so, he became willing to undergo a trial of medication.

Once we had begun to find some words for our experience together, Mr. D and I could begin to explore something about the wordless states of dread with which he was so familiar. In brief, certain of these centered around experiences with his mother, in which he believed that "she never 'gets it' with me." For example, Mr. D told me of instances where she gave him items of clothing that did not fit and that were inappropriate for the new place in which he was beginning to live. (The family made frequent moves in conjunction with the father's work.) When he tried to talk with her about his painful emotional states, she responded with non sequiturs. He felt constantly enraged when with her.

More extensive work, however, focused on another sort of "nameless dread" (Bion 1962a, p. 308) about which Mr. D was now able to speak—that of his terror of loss of identity. He spoke of his constant fear of his father's dying, and the terror and guilt he experienced when he became angry with his father, who had suddenly become weak and fragile following a massive heart attack.

Mr. D seemed to feel (unconsciously) that he had only two choices: either to deaden himself to such powerful feelings of rage, guilt, and loss, or to splinter into pieces through a demolition of his fragile sense of self in order to be nothing. He had trained in a profession, but was constantly plagued by the dread that he was not "enough." He felt lost. Mr. D reminded me that he had chosen to come see me, an analyst, because he hoped that I could help him in ways that "Western medicine" could not. The proposal to take medication had threatened to extinguish that hope. He had sought someone to listen to his misery, a person who (he hoped) would be strong enough to contain him.[4]

Mr. D was now also better able to think about and to put into words something of his (and my) experience just before the time that I made my interpretation that moved him. He spoke of how I had been a "rope" that he could hold on to when he was unable to find words for the terrifying feeling that he was about to break into pieces or to kill himself. As he spoke of this rope, I could now envision how—in being tied to one another—each of us teetered at the edge of our own personal terrors: We had been separated by a chasm, the cavernous depths of our own life experiences. I had to find a way to digest my own experience before I could grasp his without fearing that I would fall into the chasm of my own desolation.

As the patient and I became better able to talk about these sets of feelings, I recalled and began to hear in a different way the words written by the poet Rumi that Mr. D had given me five months earlier:

> When water gets caught in habitual whirlpools,
> dig a way out through the bottom
> to the ocean. There is a secret medicine
> given only to those who hurt so hard
> they can't hope.
>
> [Barks 1997, p. 52]

[4] Britton (1998) says the following about failure of maternal containment: "Bion's *nameless dread* is, I think, a manifestation of this [inchoate] terror when, in infancy, maternal containment fails completely. Later, when whole object relations are established and part no longer equals whole, it expresses itself in this more partial form of existential anxiety, the fear of loss of identify" (p. 7).

The medicine to which this poem refers is a kind of medicine that can only be "given" by another human being strong enough to assist an individual in finding a shape for emotional experience. For Mr. D, this would involve finding words to give form to and articulate his experience. In so doing, he would be creating a *form*/identity that is capacious and more durable than what he had been able to generate to this point—a form of self-experience sufficiently powerful and substantial to contend with inner and outer forces that he had to face. It had become clearer to me why the "lifesaving" medication that I was suggesting he take was such a threat to the fragile sense of hope that he possessed—the hope of developing a sense of self from the inside out, and not the other way around. It was, however, yet to be discovered why I had not (for a time) been a person sufficient to assist him in this process.

THE THING IN THE ROOM

> But the poem is also the search of the poet for his language, his own language which I, quite apart from the material theme, had to use to write at all. I had to write in a certain way to gain a verisimilitude with the object I had in mind.
>
> —Williams (1946, p. xiv)

Such unformulated, unarticulated forces as those encountered with Mr. D embody elements of unconscious experience that are initially communicated through sensory impressions that make a kind of physical impact upon the analyst. In order to learn from clinical experience, these impressions must be given a shape (i.e., must become symbolized) and then be created in words (i.e., become verbally represented), so that they may be transformed into something (interpretations or other forms of intervention) that may be used by the patient. The analyst must achieve sufficient proximity to the patient's (and his or her own) sensory experience to be receptive to what is being communicated, while at the same time maintaining adequate distance from the experience to contain it. In this way, the analyst is in possession of an imaginative

space (an analytic space) where he or she may create metaphors for what the patient's unconscious experience is like for him or her.

It is true that the narrative (content) of "The Use of Force" bears strong resemblance to the story line of my experience with Mr. D—that of forcing something into a patient. But the content was only a gateway to my use of this text. Once I entered into the experience of reading the story (and of recalling what it was like for me to have read it at an earlier time), I benefited from something far more than a plot centering around a doctor's forcing open a patient "for the patient's own good."[5] (Such a plotline on its own is mere melodrama and would have been of no use to me.) This story is alive in a way that my interpretations were not. My initial comments to Mr. D attempted to address certain aspects of his intrapsychic experience and of his and my experiences with one another, but the interventions lacked the three-dimensional quality of Williams's story, and did not capture the sensory dimensions and the immediacy of the force-field created between Mr. D and me.

What I am referring to as the *form* is not the moral of the story, but *a way of using one's mind* that is reflected in the way language works in Williams's story. "The Use of Force" provided an imaginative form—a dream space—that I could enter and then better find words to describe the emotional context in which I was attempting to force "treatment" on Mr. D. Through my reading of Williams's story and participation in its imaginative form, this literary work provided me with a way of using my mind imaginatively in "reading" and "writing" the clinical experience with Mr. D. Williams helped me bring to life in a much fuller way Bion's psychoanalytic writing—for example, his ideas concerning the forces encountered by analyst and patient in projective identification, and his conception of the process of containment.

[5] See Ogden (1997, 2001) for discussions and demonstrations of the *experience* of reading, and for his enlivening conversations with imaginative writers and their works. I am indebted to him for what I have learned from him about the psychoanalytic uses of creative writing, reading, and listening.

A DESCENT INTO MYSELF

> I lost myself in the very properties of their minds: for the moment at least I actually became them, whoever they should be, so that when I detached myself from them at the end of a half-hour of intense concentration over some illness which was affecting them, it was as though I were reawakening from a sleep. For the moment I myself did not exist, nothing of myself affected me. As a consequence I came back to myself, as from any other sleep, rested.
>
> —Williams (1948a, p. 356)

Prior to my recognition that I was attempting to be a pill in order to save the patient, I was unable to achieve sufficient self-analytic space to explore what was happening between us. I remember that when "The Use of Force" came to mind in my work with Mr. D, my initial reaction was a very visceral one: I felt relief, my body relaxed, and I felt hopeful (without knowing why). I felt relieved that I could enter this story and leave—for a moment—the world I was experiencing with Mr. D. And I did not feel quite so alone with my confusion about my experience with Mr. D, or so fearful about what would happen to him.

In my musings about "The Use of Force" and about my experience with Mr. D, I recognized that I wanted to be the strong doctor/father to Mr. D. Yet I felt so weak—and was furious about my weakness (a set of feelings I knew was related to my early experience with helplessness, fear, rage, and aloneness). I envied Williams's (autobiographically) fictional doctor for his freedom to possess an entire range of feeling states and his facility of movement among them—his capacity to feel his love for his patient (both erotic and affectionate love), his rage, and his pleasure in "the muscular release" of domination—while maintaining his intention to heal. Mostly, however, I longed to be free of the impotence I felt in treating Mr. D. The doctor in the story overcame his powerlessness through force. And, in the end, his love for his patient prevailed as he took steps to stop the disease process that had invaded her. I felt such freedom as I *became* this doctor in my reverie.

I did not initially know anything more about how this story helped me to discover the words "I think I have been trying to *be* a pill that will save you." In subsequent rereadings of "The Use of Force," I find something very striking about the way Williams constructed this story. Recall that the passage I cited earlier had no quotation marks, demonstrating the thin line between the words/feelings/actions of the narrator, the physician, the patient, and even the author himself. The lack of quotation marks momentarily causes us confusion. For example:

Don't, you're hurting me. Stop it! Stop it! You're killing me!

If you read this sentence very slowly—"Don't, you're hurting me. Stop it! Stop it!"—who is being hurt in this experience? Is it the doctor who has been "hurt" by having been rendered powerless by his patient? Even as we continue to read—"You're killing me!"—is it the doctor (whose professional identity is dependent upon his delivering treatment) who is being killed as he is made impotent, a doctor who demands that the patient stop so that he can be who he needs to be—a doctor—to her? Or do these words portray an experience of pain in Williams's life in which he used force or had force used against him?

Of course, by the time we have completed reading the sentence, the confusion is cleared up: we know that it is the patient who is screaming these words. Yet the lack of quotation marks provides sufficient ambiguity as to who is being hurt by whom that the sentences never stop suggesting that both of them feel as if they are being hurt or killed. This form itself invites us (forces us) to enter into an experience of what Williams (1948b) came to call "the thing in the room" (p. 289)—a thing that captures the palpable experience created by both doctor and patient.[6]

[6] One reader of this paper makes the following comment about the containment of affect in the literary form of "The Use of Force": "For me, it is not only the form, but the affect contained in that form, that is significant, and the affect that is consequently liberated in the analyst when reading the piece (thereby entering the form). This fits with the idea that the owner of the affect and action in the passage [from Williams's story] is ambiguous, just as it is in analysis when one is immersed in the patient's (and the analyst's) projective identifications." [Smith 2004]

But this is not the only manner in which the form of this literary construction embodies and conveys the nature of experience *between* doctor and patient. This short story constructs a drama in which "there is no separation between thought, feeling, and action . . . thought *is* action, feeling *is* action" (Surface 1998, p. 97). This rendering of experience is close to what unconscious experience may be like: an experience in which thoughts/feelings/actions run together seamlessly, where they are *forces* that make up who we are.

While the craft of fiction writing may employ certain techniques to shape imaginative texts (Stegner 1942), what I am describing in Williams's text cannot be reduced to a set of literary devices. I believe that the story communicates something of Williams's mode of conducting personal psychological work. This is a story that generates its own force.

In speaking of his clinical work, Williams (1948b) describes "the thing in the room"—a metaphor for what sometimes happens between him and a patient:

> It is an identifiable thing, and its characteristic, its chief characteristic, is that it is sure, all of a piece and, as I have said, instant and perfect: it comes, it is there, and it vanishes. But I have seen it, clearly. I have seen it. I know it because there it is. I've been possessed by it. [p. 289, italics added]

Through the impressions made upon him during the clinical moment, Williams has captured the shapes of experience of his patient's inner and outer worlds that have been communicated to him wordlessly.

But, paradoxically, he goes on to provide a remarkable metaphor that depicts the way in which the thing in the room—the experiences with the patient and the words to convey these experiences—is created in language:

> The physician enjoys a wonderful opportunity actually to witness the words being born. Their actual colors and shapes are laid before him, carrying their tiny burdens

> which he is privileged to take into his care with their unspoiled newness. He may see the difficulty with which they have been born and what they are destined to do. No one else is present but the speaker and ourselves, we have been the words' very parents. Nothing is more moving. [1948a, p. 361]

Here Williams describes a process through which language is created that captures what happens between doctor and patient. This metaphor is a fitting description for what happens in the transference-countertransference experience in the psychoanalytic situation. The analyst's role is not merely that of facilitating the birth of past experience that has been reanimated through the transference and delivered (interpreted) to the analysand; through a close reading of his own subjective response to what the patient communicates, the analyst may grasp something of the patient's emotional states as they are being procreated within the depths of the analytic experience. The analyst is moved to find words for what had been inarticulate. Thus, the analyst and analysand have become "the words' very parents." Through the act of rendering his or her experience in words that are real both to him- or herself and to the analysand, the analyst has been able to catch "the evasive life of the thing, to phrase the words in such a way . . . that will yield a moment of insight" (Williams 1948a, p. 359).

The manner in which Williams conceptualizes the thing in the room tells us something of *how his mind works* as he participates in an experience with his patients and as he finds/creates words to articulate this living thing, the experience that is conceived and given life in the room. My reaching for this story while caught in an impasse with Mr. D reflects both my desire to have my imaginative capacities stimulated and my desperate need to turn to another person to make bearable my dreadful, unformulated experience of a battle of life and death, an experience in which there was confusion (at an unconscious level) about whose life and death was at stake (the patient's or my own).

As I reflect upon the fact that my entering this short story was —in ways that I could not articulate—so liberating and enliven-

ing to me, I am struck by the freedom that Williams (and the physician he created) has in expressing an entire range of loving/erotic/tender and aggressive/hateful/homicidal/sadistic feeling states and intentions in a manner that the constructive and destructive elements are not contradictory. Not unlike the visceral experience of the fictional doctor with his patient in "The Use of Force," we metaphorically enter "the body" of living story and engage with the language employed as it succeeds in capturing human experience and processes it (the physiology, as it were, of the story's language). The raw sensory experience of the patient (both Williams's fictional one and Mr. D) was actively shaped, organized, and transformed by the containing function of another personality (Williams's writing and my own use of my experience of reading). The outcome of these containments was an enhancement of my ability to transform the transference-countertransference experience into a form that was utilizable for the conduct of psychological work.[7]

LIVING AND DYING INCOMMUNICADO

They walk incommunicado . . .
The language is missing them
they die also
incommunicado.
The language, the language
fails them
They do not know the words
or have not
the courage to use them.
—Willliams (1946, pp. 10-11)

[7] Bion (1962b) describes containment as an active process whereby the infant's/analysand's sensory and somatic experience is projected into the mother/analyst (who possesses a containing function), whereupon it is modified—given a shape/form—so that it "has become tolerable to the infant's psyche" (p. 90). The act of containment and the internalization of the containing process/function promote growth by creating the capacity for self-awareness and for thinking: "The capacity for taking in sense impressions develops together with the capacity for awareness of sense data . . . . From thoughts and the development of thoughts there arises the apparatus for thinking the thoughts" (pp. 91-92).

My writing this "story" in the form of this paper has revealed yet other clues to how I found "The Use of Force" helpful in resolving my impasse with Mr. D, as well as ways in which I am using the term *form* as I write about this subject. Further self-analytic exploration about why I was initially unable to grasp the meanings of the experience between Mr. D and me led to associations about my own father. Earlier in this paper, I noted that the compound noun *transference-countertransference* does not sufficiently capture the verblike, living form of this experience between analyst and analysand. My experience with Mr. D seemed to be all *verb*, all action/force that connects subject with object (as in a sentence). My father (as I experienced him) was little action—not so much a verb as a noun: "Dad." As a small child, I felt that I needed a father with whom I could interact and with whom I could feel safe in experimenting with my own loving and hating feelings/thoughts/actions. In part because I felt a need to protect my father (which was simultaneously an act of protection of myself), I did not feel safe in such experimentation with him. I believe that I needed not just a presence (which my father was), but an active force in my life.[8]

The psychoanalytic process, as I conceive of it, involves more than the mere presence of the analyst. The analyst and patient produce forces that must be reckoned with through the active containing presence of the analyst. These powerful forces between analyst and patient may often be communicated only through projective identification. If the analyst is not receptive to this use of the self, both patient and analyst will remain incommunicado. Here I use the word *incommunicado* to refer both to the lack of successful communication between patient and analyst, and to the resultant state of solitary confinement that is created for the patient (and for the analyst) when there are no thoughts and words to give shape and meaning to the analysand's unconscious experience.

[8] Wallace Stevens said, "The world is a force, not a presence" (quoted in Kaplan 1957, p. 640).

In my work with Mr. D, I was once again brought perforce to an experience with these elements of my own internal world as I encountered something like them in Mr. D. I turned to "The Use of Force" to help me modulate, shape, explore, and name these powerful forces within myself and between me and the patient—to stimulate my own imaginative use of the transference-countertransference. Through the medium of Williams's story, I was able to restore the capacity to experiment with myself in a manner that allowed me to free myself from the imprisoning impasse with Mr. D.

Developing the capacity for self-experimentation (for generative self-inquiry) initially requires the use of an other—a personality organization powerful enough to contain the emotional forces within. In infancy and childhood, this personality is the parent. In the analytic situation, it is the analyst. In adulthood—under optimal circumstances—an individual has sufficiently internalized the containing function that he or she has the capacity to communicate with him- or herself when faced with powerful, unformulated inner experience. The analyst in the analytic situation may provide containment for the adult whose internalized containing capacities are not sufficient to transform preconscious/unconscious experience into a form that the analysand can experiment with on his or her own. One must find a way to experiment with oneself in order to grow.

CONCLUSION

> Some kind of poetic form has to be found or I'll go crazy.
> —Williams (1932b, p. 129)

The literary forms that imaginative writers construct capture something of the way their authors *contain* psychological experience. And, while turning to a book is not equivalent to turning to an analyst, one may be affected by a fictional form in such a way that one enters not only into the universe of the narrative, but, just as important, into the universe of how the language of the work

of fiction works. In entering into the experience of reading, of being affected by the way language is used, the work may serve a holding function for the reader. This is an aspect of what Freud (1908) called "the art of creating imaginative form" (p.143), which is employed in writing original imaginative literature, and also encountered in the experience of reading it.

What we now know about the psychoanalytic process makes it possible to focus not only on the symbolic content found in forms that are created by imaginative writers. We may view these living, breathing texts as forms that are available to us as they actively create and contain (as they are form-ing) the experience of the author—and the manner in which that author does his or her own psychological work. We may view texts written by imaginative writers as containers of experience that convey the writers' sensibility and capture the unique ways that they go about shaping experience and engaging with it. Readers of these texts are provided with new perspectives and with fresh opportunities to experiment with the ways that they shape their *own* experience, conduct psychological work, and communicate with themselves and others. To a degree, this approach is not unlike the way an analysand engages with an analyst, and consequently—through the act of self-experimentation—achieves greater freedom to communicate with the self and other people.

In the analytic situation, we may on occasion use the texts of talented imaginative writers in order to hold and process our own experience, to temporarily assist us—as do our dreams and fantasies—in restoring an imaginative (self-analytic) space and in finding words for what is happening in the transference-countertransference that convey to us something of the analysand's unconscious life (and our own). Fifty years ago, William Carlos Williams (1955a) foreshadowed this use of reading (and writing) imaginative works when he wrote the words quoted at the beginning of this paper: *"[I]f you can use a poem or a literary construction to free you . . . because it breaks through, it gives you a chance to experiment with yourself."* While I have described only a single instance of an analyst's use of an imaginative work to experiment with him-

self and to achieve greater freedom, it may serve as an example of how such clinical conversations with literature may be more widely applied.

REFERENCES

Barks, C., ed. (1997). My worst habit. In *The Essential Rumi*. San Francisco, CA: Harper.

Bion, W. (1959). Attacks on linking. *Int. J. Psychoanal.*, 40:308-315.

——— (1962a). The psycho-analytic theory of thinking. *Int. J. Psychoanal.*, 43:306-310.

——— (1962b). *Learning from Experience*. London: Heinemann.

Britton, R. (1998). *Belief and Imagination*. London: Routledge.

Coles, R., ed. (1984a). Introduction. In *William Carlos Williams: The Doctor Stories*. New York: New Directions Books.

Freud, S. (1908). Creative writers and day-dreaming. *S. E.*, 9.

Kaplan, J., ed. (1957). *Bartlett's Familiar Quotations*. New York: Little, Brown & Co.

Ogden, T. (1997). *Reverie and Interpretation: Sensing Something Human*. Northvale, NJ: Aronson.

——— (2001). *Conversations at the Frontier of Dreaming*. Northvale, NJ: Aronson.

Smith, H. F. (2004). Personal communication.

Stegner, W. (1942). The shaping of experience. *Writer*, 53:99-102, April.

Steiner, J. (1993). Problems of psychoanalytic technique: patient-centered and analyst-centered interpretations. In *Psychic Retreats*. London: Routledge.

Surface, D. (1998). Using "The Use of Force." In *The Teachers' and Writers' Guide to William Carlos Williams*, ed. G. Lenhart. New York: Teachers & Writers Collaborative.

Williams, W. C. (1932a). The use of force. In *William Carlos Williams: The Doctor Stories*, ed. R. Coles. New York: New Directions Books, 1984.

——— (1932b). Letter to Kay Boyle. In *The Selected Letters of William Carlos Williams*, ed. J. Thirlwall. New York: New Directions Publishing.

——— (1946). *Paterson*. New York: New Directions Books.

——— (1948a). The practice. In *The Autobiography of William Carlos Williams*. New York: New Directions Publishing, 1967.

——— (1948b). Of medicine and poetry. In *The Autobiography of William Carlos Williams*. New York: New Directions Publishing Company, 1967.

——— (1955a). Audiotape lecture of presentation at the University of California at Los Angeles, May/June 1955, Side Two, ed. R. Swigg. Keele, Staffordshire, England: Keele Univ., 1992.

Winnicott, D. (1971). *Playing and Reality*. London: Tavistock.

Department of Psychiatry
University of Alabama, School of Medicine
1700 Seventh Avenue South, SPC 113
Birmingham, AL 35294-0018

e-mail: flgriffin@uabmc.edu