4/17/73

Kato Van Leeuwen, M.D.

Dear Kato:

There is always a problem of introducing too many things and shuffling the deck so that the audience does not know our leading card. But I have read your paper over twice and when I go back for a third reading I will underline those which appear most relevant. Another devise to avoid confusion is to summarize the contributions of authors and leave the names and reference to a bibliography at the end of the paper. My immediate next suggestion is to not change anything.

I will ramble. Countertransference reactions -- they are innumerable. Even real and felt reactions contain countertransference elements. There is no use in enumerating them -- perhaps the main criteria is "Are we in a state of mind where the patients needs are our primary concern?" Or is our narcissistic or defensive needs blurring our perceptions, particularly our third ear?

"Who is in the room besides me and the patient? The patient is obligated to bring in their dramatis personae. If I, the analyst, bring them into my associations I am to that extent "not present". Even so, which of my own ghosts are present -- and is the patient opening doors to my dear skeletons -- and how did he find the key? In his own unconscious?

Counter transference is an inevitable and essential element in the analytic process. Wagert used to say "Taste the patient. Consider what affect or phantasie he evokes in you". That is, countertransference provides data regarding the patient. She also once told me "Phil, you must analyse more with your penis." It took me awhile to appreciate this was similar to "Tasting the patient".

Lewis Hill told me that each analysis permits a reanalysis of our own analysis. And Phil Wagner has often said that despite our efforts at anomynity the patient finally knows us as well as we know the patient.

The paranoid is very skillful in telling us who and where we are. The schizoid patient knows but won't tell us. The pregnant patient complains "I expect you to be

a better mother". The obsessional tells us hardly anything, but our countertransference feelings resonate to his repressed hostility.

And then as analysis nears termination can we allow ourselves to be honest with the patient? Why not? As we should have been with our own parents, if they and we had achieved some acceptance, a reconciliation to what we were and are. The fight is over, and neither has achieved surpremacy -- we are both grateful that we knew eachother.

My feeling about pregnant patients vary. I have a young woman early in analysis with a history of previous miscarriages. Who in her past didn't want the baby? I am frankly supportive. This time we will make sure that she has the baby she wants. I tell her so. Countertransference? Of course. I want that baby but I also think I am introducing a "corrective emotional experience".

The second pregnant lady, in her third year of analysis, seems to proceed without notable concern or tensions towards the pregnancy. She and I leave that up to the obstetrician. The analysis appears to proceed as usual in a narcissistic hysteric woman. I let her rage. When the storm subsides we analyse.

Beginning with page 11 I have suggested some minor changes in wording. I was troubled by the occasional ambiguity: Who is the patient and who is the analyst? The listener can get lost if you refer to, for example "the most bothersome aspect of the analysis, without indicating in some way what this was. (page 10)

When you introduce a new illustrative experience it might be well to state this to your audience less they confuse one with the other.

Other than these minor suggestions I think you have a good paper.

With affection

Phil