

## COUNTER-TRANSFERENCE

### INTRODUCTION

Ladies and gentlemen thank you for the opportunity to speak with you about psycho-analysis. The topic for this evening, counter-transference, is a challenging one because its position in psycho-analytic thought has moved in recent years from being an unfortunate intrusion into the analytic process to being an essential aspect of the treatment method. In fact, for many, this central role of the counter-transference has led to a re-definition of the goals and methods of psycho-analysis. However, it would not be psycho-analysis if such a change did not cause controversy and conflicting opinion. I will attempt to explain what is counter-transference by following its evolution as a concept in psycho-analytic theory and practice.

By the term "counter-transference" I will be referring to the totality of the analyst's experiences about the psycho-analytic situation. I trust that the need for such a broad definition will become self-evident.

### THE PLACE OF THE CONCEPT

To begin I will focus on the defined role of the psycho-analyst in the analytic situation. In 1923 Freud, after clearly outlining his ideas about the theory and practice of psycho-analysis in a series of papers in the 19teens, gave an overview. With respect to the tasks of the analyst, the fundamental one, he directed, was to adopt a mental position of what he called "free floating attention" (SEXVIII p239). Of this he wrote,

Experience soon showed that the attitude which the analytic physician could most advantageously adopt was to surrender himself to his own unconscious mental activity, in a state of evenly suspended attention, to avoid as far as possible reflection and construction of conscious expectations, not to try to fix anything that he had heard particularly in his memory and by these means to catch the drift of the patient's unconscious with his own unconscious. (SE XVIII (p239) (Freud's italics))

In this Freud is giving an important but deceptively challenging instruction which is based upon his, then, ideas about the goal of psycho-analysis - that is, essentially, the exploration of, and the understanding of, the patient's unconscious experiences. Freud's instruction essentially is that the analyst has, in the consulting room, to intentionally free themselves from their good physicianly intentions to be able to truly assist their patient analytically. The various functions that Freud outlines the therapist must disengage themselves from are the essences of rapport and normal human interaction. Freud essentially is proposing that the therapist establish themselves as a totally separate individual, intentionally uninfluenced by the normal affective issues of human interaction, directing themselves towards their own unconscious with the belief that this, their unconscious, will be attuned to that of their patient. This is the essential level at which the listening has to take place.

This is obviously asking a great deal of any caring and concerned human being confronted by another seeking their help. But this, essentially, is what Freud is proposing. And Freud is quite clear about this; for example he writes in the same article that psycho-analysis is an exploratory procedure, for exploring the unconscious mental processes, and becomes secondarily, a treatment method

based upon that procedure (SE XVIII p235). I wish to suggest that one reason the counter-transference has become prominent in analytic theory and practise is because of the extraordinary nature of this proposition by Freud. By this I mean that Freud's proposition, innocuous at first glance but so radical upon further consideration, is so disruptive of the normal therapeutic orientation that it has provoked a movement around the concept in an attempt to find a more reasonable way of approaching it. Of course once this more reasonable conceptualization is found it will be enthusiastically embraced. This has occurred with many of Freud's ideas with Freud himself often the prime mover.

Soon after writing this article, Freud wrote his important paper "The Ego and the Id" (1923 SE XIX). This paper was written by Freud as a formal revision of his theory of mind. In other words, the conscious, pre-conscious and unconscious topographical conceptualization of the mind was revised, and the mind now was seen as constituted of the id, the ego and the addition of the superego. With this revision of the structure of the mind came also a revision of the goals of the therapeutic approach of psycho-analysis. Obviously working towards an understanding of the unconscious by the technique described was no longer directly relevant. The goal of psycho-analysis, with the corresponding revision of technique, was to assist the ego in its struggles to cope with, and deal with, the three-pronged attacks upon it from the needs of the id, the demands of the superego and the challenges of external reality. This is now the essential level at which the listening has to take place. Obviously this will entail change in the analyst's therapeutic role which therefore involved the very different task of forming a working relationship with the patient's ego to assist it in its struggles. The analytic schools called ego psychology (<sup>1</sup>Hartmann, 1964) and self psychology (<sup>2</sup>Kohut 1967) are essentially guided by this approach.

However even though there was this significant revision of analytic theory and practise, not all analytic groups have followed Freud. The followers of Melanie Klein for example remain focussed in their work upon approaching the patient's unconscious fantasies. The British analyst <sup>3</sup>Wilfred Bion, who developed and extended Klein's ideas, reintroduced Freud's original ideas in a 1967 paper he entitled "Notes on memory and desire". In this paper Bion proposed that the analyst should approach the analytic session in a disciplined and determined state of mind focussed on the elimination of all of the analyst's sensuous experiences. By sensuous experiences Bion had in mind such issues as hope, fear, anxiety, shame, guilt, desire to help the patient etc. Memory per se is not really the problem to be avoided it is the analyst's attachment to and investment in his memories that constitute the problem. Bion explained this approach in more theoretical detail than Freud. Bion outlined his belief that emotional growth could only occur by an acceptance, as opposed to avoidance, of the truth. The truth in this context essentially being the painful and, accordingly, determinedly-defended against, issues of human existence pertaining to the individual's experience. Evasion of the experience of the truth leads to the emotional and characterological stunting that underlies symptomatology. Bion's belief was that the truth can only be achieved through

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<sup>1</sup> Hartmann H., 1964, Essays on Ego Psychology, Hogarth, London.

<sup>2</sup> Kohut. H., 1967, The restoration of the Self, I.J.P. N.Y.

<sup>3</sup> Bion, W.M., (1967), "Notes on memory and desire", The Psychoanalytic Forum, Los Angeles, California.

intuition, and intuition is based upon the clear and determined movement of experience from the sensuous to the mental.

Of this the <sup>4</sup>Symingtons (1996), in their book on Bion's thinking, write,

Bion says that the psychic reality can only be known through intuition. This means that the mental-emotional reality is apprehended directly and not via the senses. Bion's proposition is that the senses block intuition of the psychic reality. Now both memory and desire are rooted in the senses and therefore they both block our intuition of psychic reality. Intuition does not occur through sense perception. Instead those moments of insight occur through an inner creative act of thought (p167)

In other words what Bion is proposing is that if psychic growth can only occur through understanding the truth about who we are, then this knowledge can only be attained through the gaining of insight and this insight can only be gained through intuition and the intuitive understanding can only be attained through a pure focus upon one's mental/emotional processes. The intrusion of sensuous experience – for example memory and desire (e.g. desire to help the patient to resolve their difficulties) – blocks intuition. Now of course it must be noted that Bion's instructions' are directed towards the analyst. The point here being if the analyst can allow themselves to receive their patient's projections at all levels and process these through their intuitive thought processes then they may assist their patient to achieve transformation in their (the patient's) experience of the analytic session. However the goal, more simply put, is that if the analyst can move towards the thinking of the truth about themselves and themselves and their patient, then they can assist the patient in the necessary movement towards the thinking of the psychic truth about themselves that leads towards psychic growth.

In parallel with Freud's instruction re free floating attention, Bion proposed that they should enter into a state of reverie. This essentially means allowing themselves to experience the session in the way Freud explained but then by turning towards their inner visual experience – in a totally honest way – they could gain access to their mental/emotional experience of the session. By this directive Bion believed he was proposing that the analyst use "negative capability". This is a term introduced by the poet Keats who wrote...

““Negative capability, that is when a man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason””

(Symingtons p169)

I am putting forward these ideas at length to emphasise that Freud and Bion both put forward, with determined and explained emphasis, their instructions for the analyst in the analytic situation. Although Freud changed his position, such a change was compelled upon him when theory revision demanded this. Bion sustained his position by a revision of the theories. This emphasis upon the challenging role for the analyst as outlined by Freud and Bion is to introduce the possibility that the evolution in the conceptualization of the counter-transference, which I am about to outline, may be a reaction against this

challenging analytic perspective. I put this forward for your consideration and will leave it open.

## COUNTER-TRANSFERENCE

Accordingly, my task now is to explain to you the changing place of the analyst's "counter-transference" experiences in the theory and practice of psycho-analysis. Let me begin at the beginning. The term was first used by Freud in 1909 in a letter to Jung. Jung, at that time, was tangled up in a relationship with one of his patients, Sabina Spielrein, and had written a quasi-confessional letter to Freud seeking something from him. How did Freud respond? He somewhat surprisingly wrote,

Such experiences, though painful, are necessary and hard to avoid. Without them we cannot really know life and what we are dealing with.

Freud continued after saying he himself had come close to succumbing to such feelings,

But no lasting harm is done. They help us to develop the thick skin we need to dominate "counter-transference", which is after all a permanent problem for us (EPF Conference Bulletin (p106) 2003)

In the next year (1910), Freud formally introduced the term "counter-transference" when he wrote

We have become aware of the "counter-transference" which arises in [the analyst] as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize this counter-transference in himself and overcome it ("The Future Prospects of Psycho-Analytic Therapy, SE XI, p144-145)

Freud did not write a formal paper on the counter-transference so we have to deduce from these comments and others what he had in mind. It would seem that Freud is proposing that the analyst's recognition of, and mastering of, their emotional reactions to their patient – obviously rather than acting them out – will be of important benefit to them in dealing with the unconscious emotional reactions to their patient. These unconscious emotional reactions need to be, as Freud indicated, recognized and overcome. However, if, as described, the role and task of the analyst is to attune his or her unconscious to that of the patient, so that he or she can truly comprehend the patient's unconscious experiences, then we have grounds for confusion. Perhaps this in part can be understood as with much of Freud by seeing that these are ideas in evolution and development. However, if we follow Freud's ideas, he would seem to be stating that the analyst's unconscious emotional reaction to the patient's unconscious constitutes a problem that needs to be resolved – overcome - and then the analyst's unconscious can be the fine-tuned tool that Freud is proposing psycho-analysis requires. Now, of course, the question arises as to whether Freud has in mind the idea of differentiation between emotional response – feeling – and other kinds of unconscious attunement. This is never made clear. However, Freud directs that each person practising or intending to practise psycho-analytic therapy, has their own personal analysis. It would seem reasonable to deduce from this that Freud envisaged that the unconscious emotional response in the analyst to their patient was constituted of not only emotional attunement but also the analyst's neurotic issues which effect the emotional reaction. This

personal analysis would be to not only recognize and overcome the analyst's own neurotic reactions to his or her patient's material, but it also would be to facilitate the use of the analyst's unconscious experience in the understanding of their patient by assisting them in becoming better able to recognize these, if we follow Freud, and to be less inclined to act on them - as in the case of Jung.

However this is obviously not all of what Freud is saying. He would seem to also be identifying a problem within such an unconscious reaction in the analyst, something that needs to be overcome. As I have suggested this may be the analyst's neurotic responses but we would have to question whether this was all Freud had in mind. Another possible reason that Freud may have been concerned about the analyst's counter-transference reaction to the patient's unconscious effects upon him, or her, was because of the possibility of a defensive reaction in the analyst to their - the analyst's - emotional response to the patient's effect upon them. This idea raises the very difficult problem with respect to how much of the analyst's counter-transference experience is the result of attunement, and how much is the result of the analyst's defensive reaction against such.

The first apparent revision of Freud's notions were the ideas put forward by the British analyst <sup>5</sup>Paula Heimann in 1950. As I have discussed Freud proposed that the unconscious of the analyst, properly tuned, could be used as an, or the, crucial instrument of psycho-analysis. For example Freud had written...

I have had good reason for asserting that everyone possesses in his own unconscious an instrument with which he can interpret the utterances of the unconscious in other people

(1923 "The Disposition to Obsessional Neurosis" SE XIIp320))

As I also put forward, this concept in itself and with the complicating Freudian notions about the counter-transference, represents a significant challenge in theory and practise for psycho-analysts. This is where Heimann comes in.

Heimann formally put forward the proposition that the analyst's unconscious experience of their patient may not only be their neurotic reaction to their patient but may also be, as Freud had in fact proposed, an important instrument for understanding their patient's unconscious. This paper by Heimann had a significant effect upon analysts who from then on turned towards their counter-transference experiences for important insights into their patient's unconscious experiences.

Of course one could wonder why this Freudian idea required this restatement before it became formally established as part of analytic theory and practise. I raise this not only as an idle question but one which may direct towards further understandings about the counter-transference. For example, the nearer to Freud, the more the counter-transference appears to correlate with the analyst's neurosis, the further from Freud, the more his more creative ideas can be adopted.

With respect to Heimann's ideas concerning the counter-transference, importantly they found support within theories being put forward by the Kleinian

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<sup>5</sup> Heimann P., 1950, On Counter-transference, I.J.P. 33 p81-84

analysts in England. Of most relevance in these was the theory of projective identification. This was first described as a defence mechanism by <sup>6</sup>Melanie Klein in which part of the ego – with its corresponding object relations – was split off from the rest of the ego and projected into the object. In Klein's original description the object became identified in the subject's mind with the split off part of their ego. In other words, in Klein's original description, the process occurred within the subject's fantasy world – they split off part of themselves, disowned it and believed it belonged to another. However what was found, for example with borderline patients, was the curious phenomenon that the object, the other person, into whom these split-off parts were fantasised to be projected, truly were effected and did in fact, in their own right, identify them-selves with what had been projected. For example, a psychiatric registrar I supervise explained to me the other day that she had been called to the emergency department of one of our hospitals to see a patient sent for admission by a senior psychiatrist.

As soon as she walked into the room to interview the patient she felt a sense of defensive inferiority and reflexly turned towards her authority and found herself criticizing, belittling and rejecting the patient. This was so out of character for her she noted it – which unfortunately does not happen very often with projective identification – and was obviously particularly interested to hear from the patient that this was exactly how his psychiatrist had treated him.

I won't go further into this example but return to the general question of what does this splitting, projection and identification actually mean? (For a full discussion of the subject see <sup>7</sup>Sandler). Let me put forward a descriptive scheme of what is thought or hypothesised to occur. The idea is that essences of our experiences can be projected into others as if this is like some form of primitive communication prior to verbal communication. True empathy is possibly a taken-for granted form of this. To be projected into others this essence of experience must be in some form – in a psychic sense – that is an antecedent to verbal language. In this form, if projected into another person, it will be experienced, by them, in some attuned way. However in this form, these essences of experience cannot be known, they can only be experienced – in the other as in the original person. However, even though they have been dealt with by projection by the original person they – the essences of experience – are still in a form in which further psychic processing may occur. If they are processed further they will eventually become part of the conscious experience of the other into whom they have been projected – in other words they will have achieved a form in which they can be recognized, experienced and expressed in a verbal conscious manner. Because these experiences were processed from unconscious origins, when they do become conscious the second person will identify themselves with, and through, these psychic experiences.

Melanie Klein hypothesised that the reason for the defensive move was to free the psyche from unwanted parts, for example an infantile needy part of the character. In other words, a part of one's psyche which threatens one's internal equilibrium can be successfully disowned by allocation to another. However further research would seem to indicate two other possibilities. One being that idealized parts of one's character can be projected into another. Two reasons for this are to preserve the part of one's character against the destructive forces

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<sup>6</sup> Klein, M., 1942, "Notes on Some Schizoid Mechanisms" I.J.P. No 27 Vol III

<sup>7</sup> Sandler, J. (1987) Projection, Identification, Projective Identification. Int. Uni. Press, USA

within - this can be seen in borderline patients who often idealized those with whom they form relationships - who can forget Glenn Close in "Fatal Attraction". Of course, this may often happen in the relationship patient's generate with their therapists and vice versa. A second reason is to enhance the value and worth of the other person, another example of such projective identification would be parents with their children, especially infants before the child has truly declared who they are, and also falling in love, which, as the poets have told us, can be a particularly depleting exercise.

A third mode or function of projective identification is one of communication. In this mode part of the inner experience is retained by the subject and part is projected into their other. This is the essence of empathy. If this mechanism is working correctly then when another person says they understand how you feel they are quite correct.

Obviously each of these mechanisms of projective identification will be extremely important for understanding the counter-transference.

Until recently these ideas about the counter-transference, that is the duality of the analyst's neurotic response and the analyst's important attunement to the unconscious of another, was the essence of the understanding of the counter-transference. As discussed, they are both based upon a certain perspective on what is the goal of psycho-analysis. This was, or is, directed towards the understanding of the unconscious of the patient. The analyst recognised their neurotic response and dealt with it as Freud insisted, and they also, following Freud, Bion and Heimann, opened themselves to their patient's unconscious and used this to work towards an understanding of the patient's inner workings that they could use to help their patients to understand themselves. The goal in this mode of analysis as per Bion was/is to help the patient to move towards a psychic growth enhancing understanding of the truth about themselves.

However, as already discussed, Freud changed his perspective on the aims and goals of analysis following his revision of his theory of mind - that is after he published "The Ego and the Id". No longer was the analyst to be the person whose presence was mainly defined by their absence. They were now to be an adjunct, a helpful assistant, to the patient's ego in its struggles to cope with the demands upon it from id, superego and reality. This obviously involved a radical revision of the analyst's role because if the patient's unconscious is no longer the focus but instead the ego and its functions, then the analyst's focus upon his or her unconscious as a way to understand the patient's is no longer necessary or even particularly relevant. In fact it would be seen as an ego-centric, almost solipsistic, distraction away from the focus on the patient's ego and its struggles. I emphasise the radical nature of Freud's revision because, in essence it has divided psycho-analysis into two major focuses - and corresponding technical approaches.

Perhaps because of this division in psycho-analytic thought, or perhaps inevitably, a further significant revision occurred essentially based upon, or, at least, very much influenced by, the ideas of post-modernism. Without going into, or doing adequate service, to these ideas, let me extract the one idea that is of central importance to the further revision of psycho-analytic thinking - for some - and that is not just that the truth is relative and not absolute but also, accordingly, it is constructed.

In other words, one cannot argue for the “the truth” as a concept that stands on its own, waiting to be discovered, or at least approached the best we may; the truth is waiting to be created. And, if two people are involved, as in the analytic situation, then the truth will await construction between and by the two of them. This means that the patient’s unconscious experience will not be reflective and expressive of the unresolved interpersonal issues of the patient’s developmental years; it will be the product of a complex interactive process involving the patient and analyst and their unconscious. Accordingly the focus of the analytic work will be upon this interactive process between the two protagonists. Of this, in a paper in the last edition of the International Journal of Psychoanalysis, <sup>8</sup> Jiménez writes

For a long time the idea prevailed that the object of psychoanalysis was the search for the truth of the unconscious. The last few decades, however, have witnessed “a redefinition of the object of [psychoanalytic] study, that is, the particular intersubjective figure constituted by the analyst-patient relationship” (Canestri, 1994, p1079). In this last sense, it is no longer possible to continue to separate investigation of the unconscious from consideration of the investigative intentions of patient and analyst, and much more is clearly involved than contemplation of the conjectured truth of the unconscious.

IJP Vol89, #3, 2008, p592

In other words Jiménez is stating that the approach of psycho-analysis upon the “conjectured” truth of the unconscious has been replaced by the focus upon the analytic couple’s interactions and in this the contribution of both parties to the construction of this interaction must be considered.

This does constitute a significant revision of psycho-analytic theory and practise and in particular the role of the analyst and their emotional experiences in this. Even though post-modernism would seem to have been tied in a knot by its truth statements about truth statements, seemingly Jiménez, at least, does not believe that its effects upon psycho-analysis have suffered a similar fate – of course we would have to wonder why not? Why have these revised truth statements about psycho-analysis not been challenged and rejected or similar self-referential grounds? At least a part answer to this question would paradoxically seem to relate to the quiet maintenance of the analyst’s dual positions within the analytic situation. In other words, on the one hand they are involved in the described creative interaction with their patient. However on the other hand they quietly and informally sustain a position outside of this to observe, define and understand. In other words, even though in this scheme the formal role of the analyst is that of the creative interaction with their patient, the analyst will still also sustain a role of detached observer; but now rather than the patient’s unconscious they will now be observing the interactive couple. By this latter positioning the analyst will both be within and outside of the construction of the truth of the session, of the interaction, and by doing so will arrest any movement into the closed self-referential circle of post-modernism.

As I have pointed out earlier, psycho-analysis, as conceived of by Freud directly correlates understanding with therapy. The question arises whether this interlocking duality of intent, of understanding and therapy, is sustained in this

<sup>8</sup> Jiménez, P B., (2008) “Theoretical plurality and pluralism in psychoanalytic practice”. IJP Vol89 No.3, p579-599

directly interactive mode. Here a significant problem can arise. If the analyst's emotional status and their psychological perspective directly influence and contribute to the events which transpire in the consulting room, then it would seem reasonable to assume that a change in the inner workings of the analyst – their emotional and psychological qualities – will have a direct effect upon what will occur in the interactive process. This would certainly seem to be true. However, the problem arises at the level of the analyst's awareness of just what are those affective and psychological factors. In other words, if the analyst is to conceive of themselves as an important factor in not just understanding what transpires but also the therapeutic outcome of the interaction, then issues of their own unconscious factors – the counter-transference in Freud's original conceptualization – are crucial. For this reason the dual role of the analyst, both within the interaction but quietly outside of it would be crucial. From outside he or she can be an involved observer of the manifestations of their own unconscious issues and their effects upon the interactive process; of course such a position is challenging and extremely difficult and requires of the analyst a significant level of sophisticated understanding both about unconscious processes in general and their own in particular.

## CONCLUSIONS

I trust I have given a reasonably coherent outline of the challenging position and role of the analyst's emotional responses to the analytic situation and the increasing level of complexity in this. Now let me put in place a summary of the different conceptualizations of the counter-transference. I will put these forward as a list:

1. Prior to and separate from the specific interaction between analyst and patient will be the analyst's feelings about psycho-analysis overall. These of course will be a complex mixture of a number of factors, e.g. the reasons why the analyst chooses to do psycho-analysis, the analyst relationship with and experiences of his or her own training analyst – in other words possible unresolved transference issues – their relationship with their colleagues and their analytic society etc.
2. There will also be more specific factors at work prior to their interaction with their patient. For example issues occurring in their private life, previous experiences with their patient, intrusive interactions with other patients etc. For example the Italian analyst <sup>9</sup>Antonino Ferro recently reported (2004)(example to be read out)).
3. The analyst obviously should be emotionally sensitive to his or her patient's emotional experiences. Empathy may be the best word for this, however to me it seems inadequate as a concept. The analyst needs to be attuned to all levels of all the emotional communications coming from their patient.
4. Within the analyst's emotional responsiveness to their patient will be the arousal of their unresolved neurotic emotional needs – stirred either by the circumstance, the analytic situation, or by the patient's transference issues. This was the original meaning of the term by Freud.

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<sup>9</sup> Ferro , Antonino, (2004) "The Analyst as Individual, His Self-Analysis and Gradients of Functioning", EPF Bulletin No.57 p135-142

5. More complex are the analyst's emotional responses to their patient which are the product of the projections into them of split off parts of their patient's experiencing ego, and their identifications with these projected elements. I have already given a sketch of this, however let me complicate this by pointing out that even though these experiences of the analyst are based upon identifications with the patient's projections, there must still be an essential element of the analyst in this. In other words, the analyst will only identify with what must have some quality of familiarity for them. That is, the analyst's emotional state, by this mechanism, will be the product of a complex admixture of projected elements of the patient and elements of the analyst. For an analyst to allocate full responsibility for their experience to the patient is incorrect and would generally indicate the analyst is slipping into a mind-set similar to that of their patient. Such problems are often seen in the treatment of borderline patients.
6. The next level is the one already discussed at length, that of the complexities of the interactive/interpersonal analytic situation. As I introduced, this level of understanding with respect to the analyst's role and the issue of their emotional state has been developed from within psycho-analytic theory and from philosophy – and, one could add, common-sense. However, as I have attempted to explain, there are complicating factors in this perspective. To be sustained theoretically, as discussed, and to close scrutiny, the analyst would be seen to be occupying a dual perspective both within and outside of the interaction. This of course creates a complex picture with respect to the place and role of the analyst's emotional experiences.
7. In the preparation of this paper I thought that this may be as far – in terms of complexity – as I should go. However I believe that that would be doing a disservice both to you and the topic. Accordingly I will take the discussion two steps further in terms of its complexity and involvement.
8. To begin the discussion of these complexities I will turn to the more difficult <sup>10</sup>Winnicott and his discussion of transitional phenomena. Although Winnicott's ideas about transitional objects are quite well known the complexity of his ideas with respect to transitional phenomena per se, as outlined in his 1971 publication "Playing and Reality", are seemingly less well known.

Winnicott's focus was upon the interface between one's inner psychic experience and one's existence in the real world and, in particular, how the transition of experience between one and the other was achieved. This issue becomes more complex when one considers how the individual infant, in the normal process of development, begins to find and define themselves in terms of their place in the real world by movement from their inner experiences. Winnicott proposes that there must, metaphorically, be a transitional space between the two, a space which, paradoxically, is neither constituted of pure inner experience or wholly experiences of the outside world. In this Winnicott referred to an essential paradox of existence, one that has to be accepted rather than resolved. This paradox, which is particularly relevant to the analyst's role in the

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<sup>10</sup> Winnicott, D., (1971) Playing and Reality. Penguin. England

intersubjective model as discussed, refers to having to be outside of inner experience to comprehend it and to be within inner experience to perceive and experience the outside world. Rather than becoming lost in this paradox and being drawn to resolve it - as in certain interpersonal models - Winnicott proposed a third area of experience, an intermediate or transitional one, in which the analyst's experience is of neither just me or not me. Of this Winnicott wrote

The task of reality - acceptance is never completed, that no human being is free from the strain of relating inner and outer reality, and.... relief from this strain is provided by an intermediate area of experience which is not challenged (arts, religion, etc).

(Playing and Reality (1980)(p15))

And

This intermediate area of experience unchallenged in respect of its belonging to inner and external (shared) reality... throughout life is retained in the intense experiencing that belongs to the arts and to religion and to imaginative being, and to creative scientific work (p16)

Further Winnicott proposed that phenomena which correlated with or could be seen to be a product of transitional experience included art and religion, creativity and play and psycho-analysis. He wrote:

The natural thing is playing, and the highly sophisticated twentieth century phenomenon is psychoanalysis. It must be of value to the analyst to be constantly reminded not only of what is owed to Freud but also of what we owe to the natural and universal thing called playing. (p48)

Relevant to what we are discussing tonight, Winnicott is directing towards the acceptance of an ambiguous or paradoxical experience by the analyst in the analytic situation. Although spelling it out is difficult, the analyst's emotional situation would involve their personal inner experience, the experience created and generated in their interaction with their patient, and their direct emotional responses to their patient's communications. However Winnicott's essential point is that the analyst's experience will be a product, a paradoxical amalgam, of all of these experiences. If one thinks about it we would have to say - of course it is, what else could it be? However, at any one time the tendency in the analyst is to declare one or other emotional response as being their emotional response. This, in essence, is resolving the paradox by declaring one of the defining experiences as the experience.

9. I wish to put forward two more related issues with respect to the analyst's emotional involvement in the analytic enterprise and then end this list. However I do not want to give the impression that the list is complete, I will bring it to an end in sympathy with your tolerance.

Let me introduce these last two issues by pointing out that the fundamental analytic position - for the analyst and also, hopefully for most analytic patients - is the endless enquiry - what does that mean? - directed towards understanding. The understanding being sought is that achieved through the basics of intuition, emotion and hypothesis.

In a paper like this in which notions re the counter-transference are being put forward, there always needs to be the place for the question - what does that mean - directed towards, and through, intuition and experience.

If we apply that question to what has been said so far - and adopt the position of ruthless honesty and dissatisfaction with and suspicion of the obvious - then I believe two more ideas - at least - present themselves and these are what I will now consider.

The first of these applies to what perhaps could be seen as a meta-level of belief and motivation in those who choose to practise psycho-analysis. This level of experience lies quietly in the background in many or most analyses but becomes a painful point of interaction or crisis in others. Lying behind the analyst's thoughts and actions will be a belief system. Although this may vary between analysts, there will be factors in common. For example they must believe that they can help bring about change in another and that this is a good thing, presumably both for their patient and others around the patient. Further they will believe that somewhere inside this patient there will be motivation for change no matter the rigidity and desperateness of their defence system. Also, further to the notion of potential for change, the analyst will believe that such change will lead to growth and development, the unfolding of obstructed potentials. And, quietly, they will also believe that their own psychic state will be enhanced by the participation in the growth and development of the patient. And, further still, in-spite of a more circumspect perspective that they will ostensibly manifest, they will believe that the growth and development in their patient and themselves will lead onto greater creativity of purpose in life and, overall, an enhanced level of happiness and pleasure.

These ideas would seem essential to the analyst to sustain them during the tedious hours with patients who don't even like themselves. But there is a fragility to such a belief system at any and every point and hence the analyst is, accordingly, potentially emotionally vulnerable. And it is very common for patients to have experienced psychic traumas to do with frustrations and disappointments within the average, expectable, basic, interpersonal experiences during their developmental years and these, if not resolved or at least corrected by further experience, may lead the patient to be functioning by a different system of beliefs and expectations than those of the analyst. Perhaps the best example of this is the so-called "negative therapeutic reaction" first described by Freud in 1918 ("An Infantile Neurosis" SE XVII (p69)). These are complex issues but my point is that, if the analyst is being sustained emotionally by a belief system that is essentially directed towards health, life and creativity, and this is emotionally important for them,

and their patient may be driven by a different system, then a potential for emotional difficulties in the analysts is always present. In this the analyst's training or personal analysis may not be of great assistance because most likely they and their training analyst will be operating in a like system.

My point is that the analyst is potentially emotionally fragile at this point and how they deal with it will be crucial with respect to how they work with their patients at such points.

I want to introduce just one more idea about the analyst's emotional reactions. Like the one I have just emphasised, this point will also lie quietly in the background. The question that needs to be addressed by every analyst, and people practising analytic therapy, is - why am I doing this? This question should always be there and never fully answered because the answer can't ever fully be known. However it does not mean it can't be approached. Let me suggest one orientation that may be adopted in such an approach. The analyst needs to ask themselves whether they are doing what they are doing because they are trying to build upon a sense of lack in themselves to further develop their individual potential and help their patient to do the same, or whether they are using the analytic encounter in a collusive way with their patient to mask the sense of lack inside of them. This sense of existential lack was focused particularly by Lacan<sup>11</sup> (in Ruti 2008) The concept being that if we are able to be totally honest with ourselves we will always find ourselves other-to. Other-to our bodies, our language, the laws we obey, the God we believe or don't believe in etc. This other-to leaves us feeling a lack - what we are other-to is lacking in our essential sense of existence. Acceptance of this allows an expansion of one's existential options. If you are essentially on your own, other-to all the issues which otherwise define you, then you pursue a self-definition by pursuing all your options. If you instead fall into the narcissistic fantasy of unity with your body, patient or analyst, or whatever other-to, then your creative potential becomes accordingly limited but you feel very much better.

From this existential perspective, therefore, the analyst's ability to accept their alterity, their otherness in all aspects of their life, will of course very much effect how they approach their patient. Again, this is a complex and, in fact, a divisive issue in psycho-analysis and I introduce it to you because of its importance.

## SUMMARY

So let me finish off with a summary of what I have said and a clinical example for us to ponder in view of the various ideas.

As I began by saying, the issue of the analyst's emotional experiences with respect to the analytic situation - the so-called "counter-transference" - has become far more complex and important in recent years. And I trust I have conveyed qualities of the complexity that have accompanied this development of the concept.

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<sup>11</sup> Ruti, Mari (2008), "A Fall of Fantasies: A Lacanian Reading of Lack, JAPA Vol 56, No 3, June 2008 p 483-508

At its simplest level the concept signifies the analyst's emotional reaction to their patient and the analytic situation both in a simple responsive and also neurotic sense. They enter the situation as a normal neurotic individual with hopes, wishes, fears and needs and are correspondingly affected. However it would seem that Freud, from the beginning, drew a line between the normal reaction of the analyst and the unconscious responses.

Building on Freud's ideas, Heimann, focusing upon the analyst's unconscious experiences and their conscious manifestations, proposed two origins for these experiences - one being the analyst's own experiences, i.e. those originating in the analyst, and the other being the patient's experiences being projected into and processed by the analyst's psyche.

At the next level is the concept that if the patient projects into the analyst then there is no reason why the analyst is not doing the same to the patient and hence the essence and focus of the analytic session is the perceived joint construction of the two protagonists. However, as discussed, to sustain such a perspective - theoretically and in practise, - the analyst has to occupy a dual position - inside and outside of the intersubjective interaction. This dual perspective for the analyst leads on to the notion of the transitional intermediary space described by Winnicott. In other words the creative position for the analyst lies not outside of or within the interaction with the patient but within a paradoxical amalgam of the two positions.

I have added a brief discussion of two difficulties, or perhaps challenges, for the analyst lying behind these ideas. The first is to do with the almost inevitable mismatch between the analyst's emotional orientation and that of his or her patient. The second being the challenge to the analyst and the psycho-analysis of the question of other-to. How does the analyst view this and proceed. The difference between analytic groups - for example the Lacanians and the ego psychologists is fundamentally based on this issue. In other words the Lacanians' view the recognition of alterity - other-to - as essential to the emotional growth of the individual in analysis, whereas the ego psychologists view the interaction between the analyst and the patient - which the Lacanians see as fulfilling the patient's narcissistic fantasies (Ruti 2008) - as crucial.

I appreciate I have covered a wide area of concepts but I could not do otherwise and do duty to the issue of what is the counter-transference.

Perhaps I can finish off with a brief clinical example to exemplify some of what I have said and also to initiate discussion. However you must appreciate the example is heavily disguised, but the essence of the analytic experience, hopefully, will still be there.

Ms. P., when she first consulted me, was a single woman in her mid 30's. As a published author she had grown tired of the genre which her publishers and readers anticipated. She felt that she needed to grow beyond this but was blocked. "Crap or nothing". In the following sessions she indicated how she and her sister, an accomplished artist, had battled eating and obsessive compulsive disorder through their adolescent and early adult years. The patient felt that her writing had at first been a panacea for this but had become more of a substitute symptom.

Ms. P., I am sure, sounds like an attractive patient; intelligent, creative, insightful, verbal etc. But, this was not the essence of my counter-transference response to her. I dreaded the sessions with her and found myself fumbling to do

trivial but necessary tasks to justify delay in seeing her even for a few valuable moments. I directed myself towards comprehending my reactions and found a sense of inner emptying in her presence. In my reverie, I perceived of the experience as a picture without a frame, a breast without a nipple. In other words, inner experience spilling out to fill an infinite void. I said to her that I suspected that she must find the sessions a terribly emptying despairing experience. The patient laughed politely and told me the opposite was in fact true. She found seeing me a warm and fulfilling experience, and that she had meant to tell me that her writing block had retreated significantly.

As she told me this I was suddenly filled with a choking and suffocating feeling of black rage. I felt overwhelmed and contemplated ending the session because of my sense of certainty I would be unable to contain this rage. I wanted, with overwhelming power, to strangle her. I stayed put – that's what we are paid for – and didn't strangle her. Slowly, over the next few sessions, I gained the impression of my rage beginning in the feeling a child may have towards a mother who gains a sense of importance and presence by generating unfulfilled need in her infant. I said something more coherent than this to Ms. P, who told me that her new novel was about a daughter who creates a fiction about her mother's suicidal state so that she can kill her with impunity as revenge for her mother's emotional deprivation. The novel was apparently set in the British ruling class but the patient indicated no doubt that her subject was her own mother whose invasive passivity and martyrdom to her children's needs had provoked what Ms. P. called speechless rage in her.

I don't want to discuss these issues at any length now and will only make a couple of observations. The first being, how my internal state was disrupted by the patient. Secondly when I sought to understand this I reached a certain level of insight. When I shared this with my patient a drastic revision of my internal state occurred. However, once I mastered this, further insight, perhaps a reconstruction, could occur. During this time of turbulence within the analyst, the patient had made significant improvement and change.

Perhaps I can leave this open for further discussion and finish here.

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