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Countertransference

An Instrument of the Analysis

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No one who, like me, conjures up the most evil of those half-tamed demons that inhabit the human breast and seeks to wrestle with them, can expect to come through the struggle unscathed.

Sigmund Freud (1905, p. 109)

[W]hen approaching the unconscious...we, patient and analyst alike, are certain to be disturbed....In every consulting room there ought to be two rather frightened people, the patient and the psychoanalyst.

Wilfred Bion (1990, p. 4)

THERE HAS BEEN an awareness from the earliest days of psychoanalysis that the analyst is deeply, sometimes disturbingly, affected by engagement with the patient's unconscious experience. Sigmund Freud (1910) coined the term *countertransference* to refer to the therapist's *unconscious* reaction to the analysand's transference and noted that handling one's emotions toward the patient presented the analyst with a significant challenge. It was recommended that the clinician use the countertransference as a stimulus to self-analysis so that

one's capacity to listen to the patient's concerns could proceed without interference from the analyst's private reactions. In this chapter, I review the development of the concept of countertransference from initially being seen as a hindrance to later perspectives that view it as a means by which to better understand the patient, thereby enhancing the therapeutic process.

In a letter to Freud dated April 7, 1909, Karl Abraham referred to taking on two new patients and remarked that with each new treatment his understanding of analysis increased. He also observed:

> I have tracked down a symptomatic reaction in myself. While I am analyzing and am waiting for the patient's reply, I often cast a quick glance at the picture of my parents. I know that I always do this when I am following up the infantile transference in the patient. The glance is always accompanied by a particular guilt feeling: what will they think of me? This has of course to do with my separation from them, which was not too easy. Since explaining this symptomatic action to myself, I have not caught myself at it any more. (Abraham 1909, p. 88)

Abraham's next thoughts are of his 2-year-old daughter, to whom he had recently given enemas and who, on each following day, expressed hope there would not be another. However, he noted that the plea was offered "with a rather arch smile. So obviously she wants to get the injection. Apart from this, she does not show any analerotic tendencies" (p. 88).

There is a sense of Abraham's prideful accomplishment in this note to his good friend in having "tracked down a symptomatic reaction in myself" and not having "caught myself at it any more." This has been achieved through the analyst's observation of his reaction to the patient's infantile transference, a reaction he has had with other patients that is considered to be a distraction from his task of listening carefully to the analysand's associations. Abraham then engages in a piece of self-analysis: he realizes his guilt is connected to his "not too easy" separation from his parents, and this insight has subsequently freed him from similar diversions. In essence, he has succeeded in three ways: first, by recognizing his distracting personal reaction stirred by the patient's "infantile transference"; second, by engaging in self-analysis to remove this "symptomatic reaction"; and last, by returning his attention to the analysand's narrative.

This brief vignette is a veritable gold mine that contains within it the multitude of potential meanings given to the term *countertransference* from its inception as an inevitable, albeit distracting, factor in analysis to contemporary perspectives that consider it an essential ingredient of the psychoanalytic process. For Abraham and his cohort, emotions evoked in the analyst were expectable (e.g., the quotes from Freud and Bion at the beginning of this chapter) and served to foster his or her own self-reflections from which personal growth as an analyst and individual developed. It was, therefore, very clear from the earliest days of psychoanalysis that powerful, even deeply disturbing emotions were a common side effect of this work and that it was unrealistic to "expect to come through the struggle unscathed."

If we scratch the surface of Abraham's communication with Freud, there are many other layers of meaning that await our discovery and raise important questions about the analyst's subjective reactions. Why, for example, does Abraham look at the picture of his parents and feel guilt precisely during the interim between interpretation and the patient's response? Is there some sort of unconscious need for approval, and worry of making an error, that is being evoked in this analyst by this particular patient at this single moment in the analytic work? Abraham does not feel this guilt with every analysand: does his contriteness surface with all facets of the patient's infantile neurosis or with certain themes? Does the analysand "sense," unconsciously or not, the analyst's anxious anticipation of the patient's reply, and if so, might he or she withhold associations to the interpretation? Is there some ambient, although unarticulated, emotion permeating the session that has to do with being a "good" boy, analyst, or patient that is expressed in various ways, such as Abraham's reporting to Freud that he is a dutiful analyst or that he glances at the picture of his parents? Finally, what are we to make of Abraham's thoughts turning next to his constipated daughter and her ambivalence about the enemas? Is this an "association" that is relevant to his "symptomatic reaction" and to the analysis?

Thus, much of the "raw material" from which additional definitions of countertransference have been crafted is implicit in the letter from Abraham to Freud, and it has been left to subsequent generations to expand on it. I begin with a discussion of Freud's views of countertransference, which were often seemingly at odds with one another, and the perspectives of the early analysts. I then discuss later contributions in order to highlight the development of our understanding of the analyst's subjective reactions and how these are employed in the analytic encounter.

Freud and the Early Analysts on Countertransference (Pre-1940)

The question of the countertransference and how it should be handled was at first discussed informally as in Abraham's (1909) letter and appears for the first time in Freud's (1910) publications when he stated that such feelings arise in the analyst "as a result of the *patient's influence on his unconscious feelings* [and that the analyst should] recognize this counter-transference in himself and overcome it" (p. 144, italics added) and that "no psychoanalyst goes further than his own complexes and internal resistances permit" (p. 145).

These brief quotes are very significant in that they state that 1) the countertransference results from the impact of the patient's difficulties *on the analyst's unconscious;* 2) because such emotions in the analyst are unconscious, he or she must strive to become aware of this reaction "and overcome it"; and 3) the progress of an analysis also depends on the analyst being aware of his or her own "complexes and internal resistances." Thus, Freud is describing psychoanalysis as an intense interpersonal process in which encounters with the patient's unconscious deeply impact the unconscious of the analyst, an effect that the clinician must overcome. Failure to do so may impede the course of the patient's analysis and, it is implied, possibly hinder the personal growth of the analyst.

The growing realization that countertransference was an inevitable and sometimes destructive phenomenon led to the requirement that all analysts have a personal analysis as part of their education. This became one of the three pillars of training, in addition to attending seminars and seeing analysands under supervision, that was introduced by Max Eitington (the "Eitington Model" of training) when he founded the Berlin Psychoanalytic Polyclinic in 1920. Indeed, as Balint (1954) observed, Eitington may have received the first "training analysis," as described in a letter from Freud (1909) to Ferenczi, "Eitington is here. Twice weekly, after dinner, he comes with me for a walk and has his analysis during it" (cited in Balint 1954, p. 157). These strolls must have had a very positive effect that stayed with Eitington and contributed to his instituting the necessity of a training analysis.

However, Freud also offered other views that suggested countertransference feelings could be of benefit in an analysis. The vignette from Abraham's letter cited earlier points to how the therapist's subjective reactions may be a stimulus to self-analytic work and personal growth in the analyst. In addition, Freud (1912) also recommended that the analyst "use his unconscious . . . as an instrument of the analysis" (p. 116), although he did not instruct us as to how this is achieved. In the same paper, he proposed that the free associations of the patient and the "evenly suspended attention" of the analyst are linked phenomena; however, Freud and his contemporaries only explored the impact of the analysand's unconscious on that of the clinician, leaving aside the effect of the analyst's unconscious on the patient. In connecting the subjective emotions of the analyst and patient, Freud may have been suggesting that the therapist can use his unconscious "as an instrument of the analysis" by paying attention to his countertransference feelings.

These early analysts also examined how successful work on the countertransference was necessary for unlocking the analysand's life-constricting conflicts. If Abraham, in the case introduced at the beginning of this chapter, had not become aware of his "symptomatic reaction" that was stirred by his patient's infantile neurosis and had instead blocked recognition, this denial could have thwarted the analytic progress. Freud (1910) noticed this tendency when he wrote that unrealized "internal resistances" in the analyst can limit his or her emotional freedom, thereby tying the analysand's emotional development to the clinician's capacity to manage his or her countertransference. Some years later, Theodor Reik (1924) expanded on this point by introducing the notion of *counterresistance,* which is a subtype of countertransference in response to an obdurate resistance in the patient characterized by "a decrease of interest in the case or even a change in the mode of treatment" (p. 150). Glover (1927) subsequently added that a counterresistance was an expression of the analyst's *negative* countertransference—that is, aggression toward the patient.

Freud is often faulted for having advocated that the analyst should remain opaque and manifest the surgeon's dispassionate attitude of "emotional coldness" (Freud 1912, p. 115). However, it is important to note that these first psychoanalysts struggled with the heat generated by the transference-countertransference matrix, and I suspect that the goal of "emotional coldness" was likely a fantasied state aimed at cooling down the necessary but searing emotions of the analytic consulting room. Freud (1913) seemed to be saying as much in a letter to Binswanger dated February 20 when he stated that the problem of countertransfer-

ence was "among the most intricate in psycho-analysis" (p. 112) and that the analyst must display to the patient "spontaneous affect, but measured out consciously at times" (p. 112). He implied that some patients may require more of this than others, "but never from one's own unconscious" (p. 112). Thus, Freud appears most concerned about the heat of the analyst's unconscious affecting the analysis negatively; hence his advocacy of "emotional coldness" is meant to help the clinician keep his or her "cool" rather than to promote an air of aloofness.

Before leaving this section, there is a statement by Freud (1912) that deserves our attention: It is as contemporary as any offered by current writers and lays the groundwork for the contributions of many recent analysts:

> [The analyst] must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient...so the doctor's unconscious is able, from the derivatives of the unconscious which are communicated to him, to reconstruct that unconscious, which has determined the patient's free associations. (Freud 1912, pp. 115–116)

Although Freud does not elaborate on this observation, he offers a model of unconscious communication as an additional perspective from which to understand countertransference. Implicit in this vertex is the notion that the patient's unconscious *actively* conveys a communication for the "doctor's unconscious" that functions like a "receptive organ" to receive and then "reconstruct that [communicating] unconscious." Perhaps Freud had in mind Ferenczi's (1911) letter a year earlier in which he suggested that the countertransference was "being induced" (p. 253) by the patients, thus implying a purposeful function to this emotional induction.

Freud (1923) introduced the *structural theory* (id, ego, superego) that subsumed the previous *topographic theory* (conscious, preconscious, unconscious) and also outlined a new *theory of anxiety* (Freud 1926) that placed great importance on the role of defense mechanisms in the ego's armamentarium for managing anxiety. This important evolution in psychoanalytic theory also signaled a shift in emphasis away from the study of *unconscious [id] fantasy contents* toward the workings of the *unconscious ego* in defense. Consequently, the exploration of countertransference, which was defined as the unconscious reaction to the analysand's unconscious expressions, faded and tended to be seen as "unscientific" (Lothane 2006) as compared with the examination of the ego's functioning that could be more easily observed. Ego psychology subsequently became the predominant theoretical orientation in the United States and was galvanized by the influx of orthodox Freudian analysts from the European diaspora of World War II. However, ego psychology did not achieve the prominence in Europe, and especially South America, that it was accorded in institutes under the aegis of the American Psychoanalytic Association (Brown 2009, 2010, 2011). Consequently, most American analysts were trained to adhere to Freud's (1910) admonition to "recognize this counter-transference and overcome it" (p. 253) even though Freud (1912) had hinted at the relevance of countertransference for understanding the patient's unconscious communications.

Use of the Countertransference as an "Instrument of the Analysis" (1940–1960)

There was a significant shift in the understanding of countertransference during this period from viewing it as an encumbrance to treatment that must be overcome to seeing countertransference as an essential "instrument of the analysis." The 1930s ended with Alice and Michael Balint's paper that debunked the notion there could be a "sterile" manner of analyzing free from effects of the analyst's personality; indeed, they argued that there was an interaction between the transference and countertransference "complicated by the reactions released in each by the other's transference onto him" (Balint and Balint 1939, p. 228). They also observed that patients adapt to the analyst's countertransference and go on in analysis to "proceed to their own transference" (p. 228). In addition to normalizing the presence of countertransference feelings, the Balints also brought for our consideration the effect of the analyst's subjective experiences on the analysand; however, their view was that the patient worked around the countertransference, and they did not discuss in detail its effect on the analysand's transference.

Robert Fliess, in his 1942 paper "The Metapsychology of the Analyst," examined in great detail the nature of the analyst's *work ego* that depended on a capacity for *trial identification*, which required the analyst "to step into his [patient's] shoes and obtain in this way an

inside knowledge that is almost first hand" (p. 212). It was through this process that the analyst could use his or her countertransference as an instrument of the analysis by obtaining a "taste" of the analysand's struggles through a transient identification in which "he becomes the subject himself" (p. 215). Now armed with the "firsthand" knowledge, the clinician may make a more accurate interpretation to the analysand; however, Fliess cautioned the analyst to take care "to guarantee that no instinctual additions of our own distort the picture" (p. 219), a view that appears to partially espouse the outlook that the countertransference is something to be "cleansed." Nevertheless, Fliess's perspective represents a significant departure from the first analysts who considered the countertransference as a distraction to listening to the patient, albeit a potentially helpful one to the analyst in self-analysis.

Although Fliess does not use the term *analyzing instrument,* he is essentially offering us an insider's look at the process occurring in the analyst's mind. Thus, by introducing trial identification, the work ego, and other concepts into our lexicon, contributions that, as Schafer (2007) stated, helped "launch psychoanalysis towards its contemporary form" (p. 698), Fliess expanded the range of conceptual tools to apply to our understanding of how to use the countertransference. As discussed earlier, beginning in the 1930s there was a divide between the ego psychologists' attempts to develop techniques that sought to "cleanse" a patient's material from being alloyed with countertransference and another group's (the Balints, Fliess) views of countertransference as a pathway to the analyst's empathic understanding. In my opinion, we can see in Fliess the tension between these two perspectives: his open advocacy of the relevance of the analyst's subjective experience on the one hand and his wish to be "able to guarantee that no instinctual additions of our own distort the picture" on the other. As Jacobs (2007) commented: "One suspects that issues of loyalty to Freud, as well as fears of Ferenczi's influence and of wild, undisciplined behavior on the part of colleagues, influenced Fliess and others who held this idealized and sanitized view of the analyst's functioning" (p. 717).

The Kleinian School and Projective Identification

Melanie Klein (1946) introduced the term *projective identification* to describe how the attribution (by projection) of aspects of the self to the internal image of an object (in the projecting subject's inner world) changes the inner experience of that object. The internal object thereby becomes *identified* with what has been projected into it, and the patient's behavior toward the actual external object is governed by his or her inner experience of that object. In more disturbed patients, such as psychotic and severely borderline individuals, the distinction between inner and outer reality may be erased, whereas neurotic patients are capable of understanding their distortions that create the feeling, for example, of "it's *as if* you are my father." Klein's followers saw in projective identification a way of explaining countertransference: that the analyst's subjective reactions, in addition to his or her transference to the analysand's transference (the classical explanation), may have been created by projective identification. In this regard, countertransference could be partly explained by the patient's unconscious placement of painful emotions into the therapist; thus not only does the patient's subjective experience of the clinician change, but *the analyst is emotionally affected by what is projected.*

However, although Klein did acknowledge it was sometimes difficult for the analyst to be the recipient of such projective identifications (Spillius 2007) because of his or her associated inner objects stirred by the projection, she, like Freud, stressed that the countertransference was to be dealt with by the analyst in one's self-analysis. Despite the fact that many of her devotees regarded countertransference induced by the patient's projective identification as a useful tool of analytic work, she remained skeptical of its relevance as a guide to emotionally understanding the analysand. She held this position firmly to the end of her career: witness her comments to a group of young analysts in 1958 (quoted in Spillius 2007): "I have never found that the countertransference has helped me to understand my patient better. If I may put it like this, I have found that it helped me to understand myself better" (p. 78).

Paula Heimann (1950), the first of Klein's followers to apply the concept of projective identification to the study of countertransference, asserted that it "is an instrument of research into the patient's unconscious" (p. 81) and also that it is "the patient's creation, it is part of the patient's personality" (p. 83). Thus she linked Freud's (1912) recommendation that the analyst use his unconscious "as an instrument of the analysis" to Klein's projective identification, seeing the latter as the means by which the patient's unconscious communicates with that of the therapist. By asserting that the countertransference is a *creation* of the patient, Heimann also effectively explained the mechanism by which the countertransference is *induced* (see Ferenczi's and the Balints'

earlier comments) as well as how the analyst *becomes* a part of the patient (Fliess). Perhaps Pick (1985) said it best when she noted, "The child's or patient's projective identifications are actions in part intended to produce [emotional] reactions" (p. 157).

Roger Money-Kyrle (1956) advanced Heimann's ideas and elaborated them further. Like others before him, he observed that there are inevitable periods during which the analyst fails to understand the analysand; these occur when an aspect of the patient disturbingly coincides with an unanalyzed portion of the analyst's psyche. Money-Kyrle added an original element to this situation by stating that one task of the analyst is to interpret the effect of the countertransference on the patient; however, it is important to note that *he did not favor disclosing one's feelings directly to the patient.* Instead, he suggested that the analyst deal with the patient's comment about his or her mood, whether accurately perceived or not, by interpreting it as psychic reality that has personal meaning to the analysand. Money-Kyrle's perspective, therefore, squarely places the emphasis on the unconscious meanings both the analyst and patient attribute to their interaction. He argued that acknowledging the analyst's conscious feelings toward the patient may "confirm" the accuracy of the patient's perceptions, but it does little to address the unconscious meaning the patient has attached to the perception (accurate or not) of the analyst. Betty Joseph (1975) summed up this stance when she stated, "It is important to show, primarily, the use the patient has made of what he believes to be going on in the analyst's mind" (p. 80).

Simultaneously with these applications of projective identification by Heimann and Money-Kyrle in London, analysts in Argentina and Uruguay were exploring similar territory. The cultural ambience of the Argentine Psychoanalytic Association, which was formed in 1942, was one that combined psychoanalysis (with a primary Kleinian orientation) with input from Kurt Lewin's "field theory," studies of dreamlike states, and probed into the nature of psychosomatic states (Bernardi 2008). Heinrich Racker, one of the leading figures in the early days of the Argentine Psychoanalytic Association, believed, as did Heimann, that the capacity to identify with the patient is the "basis of comprehension" (Racker 1953) of the analysand. His investigation of the role of identifications in countertransference was considerably more detailed than contributions on the subject from any previous authors.

Racker (1957/1968) delineated what he termed *concordant* and *complementary identifications* that comprise important elements of the countertransference. Concordant identifications denote the analyst's introjection of an aspect of the patient's self ("sent" by projective identification), in which case the analyst unconsciously feels "this part of me is you" (pp. 134–135). In contrast, a complementary identification signals that the analyst has identified with an internal object of the patient. Racker, more stridently than Money-Kyrle and Joseph, asserted that the analysand is attuned to the countertransference and that the patient's awareness of the fantasied and real countertransference is a determinant of the transference: "Analysis of the patient's fantasies about countertransference, which in the widest sense constitute the causes and consequences of the transferences, is an essential part of the analysis of the transferences" (p. 131). However, the clinician must be attuned to the possible development of a *countertransference neurosis* in which the patient, in the analyst's unconscious, is equated with a disavowed part of the analyst. In such a situation, for example, the analysand may become identified with the analyst's projected aggression, and with the patient now being experienced as embodying hostility, there may be a misrecognition by the analyst that guides his or her interventions.

We can see how Racker deepened our understanding of variations in the countertransference that assists the therapist in using his or her feelings toward the patient as "an instrument of the analysis." It is important for the analyst to be able to discern whether countertransference feelings result from an identification with a disowned segment of the patient's self (concordant) or from an identification with a figure from the analysand's inner world (complementary). Leon Grinberg, a colleague of Racker, coined the term *projective counteridentification* to describe the impact of the analysand's violent projective identifications (discussed later) upon the analyst's subjectivity. As we have seen, it is essential that the analyst *become* through a temporary identification what the patient is projecting; however, there are certain situations in which the analyst "ceases to be himself and turns unavoidably into what the patient unconsciously wants him to be" (Grinberg 1990, p. 84). Grinberg contrasts the concept of projective counteridentification with Racker's idea of the complementary countertransference. When the analyst is under the impact of a complementary countertransference, his or her identification with the projected internal object of the patient stirs a personal reaction based on the analyst's idiosyncratic conflicts similar to that which is projected. By contrast, with projective counteridentification, "the same patient, using his projective identification in a particularly intense and specific way, could evoke the *same countertransferential response* (projective counteridentification) in different analysts" (Grinberg 1990, p. 90, italics added).

Bion and Communicative Aspects of Projective Identification

Wilfred Bion, a strikingly independent thinker, was trained in the London Kleinian (second analysis with Melanie Klein) tradition and creatively expanded on some basic Kleinian concepts. Grinberg's (1990) notion of projective counteridentification was based on the idea of *violent* projective identification that denotes the effect on the analyst of a patient's relentless barrage of accusations, for example, that the analyst hates the analysand. As such an attack continues, sooner or later the therapist will come to hate his or her patient independent of the analyst's attempts to remain composed or "neutral." Winnicott (1949) wrote convincingly about the necessity of the clinician coming to hate certain kinds of patients, which was an essential part of the treatment. Thus, violent projective identification *creates* an experience in the analyst of being passively taken over by a patient whose sole interest is to *evacuate* his or her own frightening emotions into the analyst.

Bion, who worked analytically with many psychotic and borderline patients, wrote a series of papers in the 1950s in which he described the *communicative* aspects of projective identification (Bion 1957, 1958, 1959). In essence he was asserting that although projective identification may serve the function of emptying out the psyche of unwanted elements, *it is also a means of emotional communication from one psyche to another.* In this connection, even the most violent expression of projective identification that leaves the therapist feeling battered is also a communication of the nature of the patient's anguish. Bion deeply believed in this, a conviction that led him to claim the patient as the analyst's best ally because even in his or her most disturbing interactions, the patient was attempting, however feebly or ferociously, to communicate something of his or her own inner suffering. Thus, Bion (1990) came to observe (cited in the quote at the beginning of this chapter) that "we, patient and analyst alike, are certain to be disturbed" (p. 4).

In proposing the communicative component of projective identification, Bion, although he did not say it directly, was in effect telling the analyst how to use his or her unconscious as "an instrument of the analysis." Communicative projective identification, therefore, was the means by which "the transmitting unconscious of the patient" (Freud 1912, p. 115) communicated with the "receptive organ" of the analyst's unconscious. However, we may also wonder about the fate of that which is projected into the therapist: what becomes of it once it has been successfully communicated and taken in, or *introjected,* by the receiving unconscious of the analyst? Bion (1958) commented that in addition to its communicative aspects, projective identification also aims to "put bad feelings in me and leave them there long enough *to be modified by their sojourn in my psyche*" (p. 146, italics added). The conception that feelings are "modified by their sojourn" in the analyst's mind became the cornerstone of Bion's later theories and furthered our understanding of countertransference; thus, another facet of countertransference was its role in modifying what has been transmitted to the clinician's unconscious.

Bion's researches into how the psyche modifies the projection led to his discovery of *reverie,* but first a detour back to Abraham's (1909) letter to Freud offers a useful illustration. As a thought experiment, I suggest we imagine ourselves as Abraham's supervisor as Abraham is describing his treatment of the patient with whom he experiences the need to look over at the picture of his parents while awaiting the analysand's reply to an interpretation. Abraham tells us that, in the classical mode, he has successfully stopped this "symptom" of gazing at the picture. Applying the notion of communicative projective identification, we may wonder whether this analyst's (Abraham) unconscious has received some communication from the patient's unconscious and that looking at the picture of his parents was this analyst's unique way of unconsciously registering in his own metaphor the patient's communication. Furthermore, we might also consider Abraham's next thoughts about his daughter's constipation and her "rather arch smile" about the enemas as further data, encoded in the analyst's personal experience, about what the analysand is unconsciously communicating. Employing the analyst's seemingly "unimportant" side remarks as his unconscious representation of the patient's subliminal communication furthers the analyst's ability to use his unconscious "as an instrument of the analysis."

Further Elaborations of Countertransference: Enactments and the Concept of a "Two Person" Psychology (1960–1990)

Bion's (1962, 1997; Ogden 2003a, 2003b, 2004) concept of *reverie* refers to a wide range of experiences (visual images, seemingly irrelevant thoughts, random tunes) that spontaneously come to the analyst's mind while listening to a patient and signal that the analyst's unconscious is quietly working to decode the analysand's unconscious communication and "re-register" it in the therapist's personal idioms. If the clinician applies this stance, then what we consider clinical "material" that is relevant to the patient's difficulties is greatly broadened. Thus, within this frame of reference, Abraham's thoughts (associations?) about his daughter's constipation are viewed as a "legitimate" potential source of information about what the patient is communicating in this session. We may therefore formulate a hypothesis that Abraham's glance over at his parents' photograph for approval that is followed by thoughts about his daughter's bowel difficulties is a reverie that indicates his unconscious reception of a communication from the analysand that is transformed into these particular thoughts. Furthermore, his unconscious may be a lightning rod for the patient's emotions about being good (Abraham's looking toward his parents) and being withholding (his daughter's constipation), and perhaps an enticement to draw Abraham into some sadomasochistic struggle (the "arch smile").

I can imagine at this point that the reader may be wondering whether these extrapolations from the analyst's countertransference are at best extremely fanciful and at worst a gross misuse and misapplication of countertransference. Indeed, this was the objection in most American psychoanalytic circles in the beginning of the 1960s regarding the use of countertransference "as an instrument of research into the patient's unconscious" (Heimann 1950, p. 81). For example, Ross and Kapp (1962) wrote a very interesting paper in which they recommended that the analyst pay attention to *his or her* visual images stirred by listening to a patient's dream because these images could offer clues to countertransference feelings of which the therapist was unaware. Whereas for Bion or Heimann such images might be considered vital data about the patient, Ross and Kapp considered these images as confirmations of "when a countertransference problem has already been suspected" (p. 645)—that is, information about the analyst and *not* the patient.

There were, however, a number of American analysts who earlier advocated using the countertransference as a means of better understanding the patient in addition to themselves, but their ideas did not gain much traction. Indeed, Theodor Reik's (1948) book *Listening With the Third Ear: The Inner Experiences of a Psychoanalyst*, which argued for the value of the analyst's subjectivity ("third ear") in understanding the patient, was widely read among the general population but seemed to have much less impact on mainstream American psychoanalysis.

In the late 1950s and early 1960s, Otto Isakower (1957, 1963) of the New York Psychoanalytic Institute gave a series of lectures dealing with supervision in which he emphasized the importance of teaching candidates to use their countertransference as a component of the "analyzing instrument." He reported his supervision of an analytic trainee who shared with an analysand a spontaneous visual image he experienced while listening to the analysand, which Isakower discussed as having had a positive treatment effect. This presentation was met with many negative responses from the audience (Wyman and Rittenberg 1992), including the comment by Martin Stein that questioned whether the candidate's sharing of the visual image "has to do with some unanalyzed personal problem. To use an analogy from medieval times—when a person had a vision to tell, was the vision sent by God or the Devil?" (p. 221).

Otto Kernberg (1965) published a groundbreaking (for American psychoanalysis) paper in which he detailed two currents in thinking about countertransference: one was the "classical" definition that regarded countertransference as the analyst's unconscious reaction to the patient's transference and the second use was the "totalistic" one, characterized by a broader view of countertransference as something that "should be certainly resolved [and also] useful in gaining more understanding of the patient" (p. 39). He described various countertransference difficulties that may await those who undertake the treatment of seriously disturbed patients and warned that the analyst should take care to recognize the possible development of "chronic countertransference fixation" that arises from the "reappearance of abandoned neurotic character traits" (p. 54) in the analyst triggered by primitive aspects of the patient.

It is important to note that this article was written during the time when he was investigating the intensive analytic treatment of patients with "borderline personality organization" (Kernberg 1967) and narcissistic disorders, and this publication argued that the analyst adopt the "totalistic" approach to countertransference as a necessary tool for treating such individuals. Although this paper did not offer new innovations in understanding the phenomenon of countertransference, its linkage of particular emotional reactions in the analyst to specific severe diagnostic states and the fact that it was published in the *Journal of the American Psychoanalytic Association* introduced most American psychoanalysts of that era, largely under the sway of then-prevalent ego psychological models, to a broadened ("totalistic") view of countertransference.

Kernberg's advocacy of the "totalistic" approach to countertransference helped to foster an evolution from a "one-person" to a "two-person" psychology in American psychoanalysis that began in the mid-1970s. Although Modell (1984) is generally credited with coining this distinction, the term *two-person psychology* is first mentioned by John Rickman (1951), who defined it as "the psychological region of reciprocal relationships" (p. 219) that takes into account the interaction between the psychologies of the analyst and patient. In this regard, Joseph Sandler (1976) introduced the idea that the transference has an intended purpose of *actualizing* an internal object relationship of the analysand in the analytic relationship. The patient assumes a certain role in accord with an internal fantasy and also deliberately, although unconsciously, acts to evoke in the analyst a complementary role of that fantasy. Sandler emphasizes that this *role responsiveness* is not just a fantasy existing in the patient's psyche but an actual state of emotional affairs that permeates the subjective experiences of the analyst and analysand. He treads on familiar ground to what Racker had earlier described but emphasizes the *pressure brought to bear on the therapist to behaviorally step into a role that is scripted by the patient's internal fantasy.* Sandler advised the clinician to maintain a *free-floating behavioral responsiveness:* a receptive capacity to being placed in a variety of roles that pull him or her in the direction of specific actions delimited by the nature of the role he or she has been pushed to assume. The analyst may be placed in a role that causes some distress, and Sandler cautioned him or her not to simply view this upset as a mere "blind spot" but to consider this reaction as a "compromise formation" between the analyst's own proclivities and his or her reaction to the nature of the role forced on him or her:

> Johnny, a 9-year-old boy in analysis for encopresis, began a session by announcing, "Dr. Brown, today we're going to kill women!" He motioned to the wall, said that there was a lineup of women whom I was supposed to shoot, and placed an imaginary gun in my hand. I was taken aback by this command and hesitated, offering that I did not know how to fire a weapon, but Johnny barked like an angry sergeant "Do it!" Still I hedged and said I didn't feel right killing these women, but my delaying was quickly remedied when Johnny turned me into an emotionless robot. His impatience with me grew until he held a rifle to my head and said, "It's them or you!" Reluctantly I gave in, followed orders, and shot all the women. Returning to my human form, I said I felt badly about the murders, at which point Johnny gave me a puzzled look and said, "Dr. Brown, we were only playing." Johnny needed me to adopt the role of a murderer of women, but my anxiety about assuming that position caused my resistance. This resistance arose from a "compromise formation" between the role Johnny needed me to step into and my conflicts over matricidal feelings (I knew the women represented his mother). Furthermore, because I believed that Johnny could not tolerate owning his matricidal impulses, my "resistance" also arose from a projection of my own conflicts into my experience of him.

Sandler moved the classical analytic understanding of countertransference forward to include the patient's pressure on the analyst to take on a role in the analysand's inner world and the effect on the analyst in acquiescing. Thus, when Johnny said, "Dr. Brown, we were only playing," it was as though he implicitly understood Sandler's technical suggestion that the analyst *become* one of the patient's inner objects or a disowned aspect of the analysand. However, it is through the experience of "role responsiveness" that the analyst is able to gain knowledge of the patient's inner workings. Thus, Sandler expanded on the analyst's use of the unconscious as an instrument of the analysis by giving privilege to the pull on the analyst to *act* in a particular role that may offer insight into the nature of the analysand's inner drama that is played out in the therapeutic situation.

The emphasis in Sandler's paper on the patient's pressure for the analyst to assume a role and act it out provides a central theoretical grounding for the focus on *enactments* beginning in the analytic literature in the 1980s. In Sandler's concept of role responsiveness, it is the patient's inner world and its externalization into the analytic situation that spur the analyst's involvement—that is, *the analyst's psyche is viewed as reactive rather than as an active participant in initiating the interaction.* Beginning in the late 1970s, Theodore

Jacobs (1991) wrote extensively about the actualizing component of enactments, adding a two-person dimension that was essentially absent in Sandler's discussion, bringing us closer to the "region of reciprocal relationships." The patient and analyst may engage in an unconscious mutual enactment that serves resistance:

> [T]he enactments carried out by both patient and analyst.... Their investigation opened the way, not only to uncovering an essential piece of history that had not yet surfaced, but to bringing to the fore certain crucial aspects of the interaction between patient and analyst that, arousing anxiety in each and strongly defended by both, had until then been insufficiently explored. (p. 40)

For Jacobs (1983), the analyst is typically drawn into an enactment because of his or her unconscious resonance with an aspect of the conflict that the patient is manifesting. Not uncommonly, the analyst identifies with an internal object of the patient who may represent a figure in the analyst's inner world or a split-off piece of him- or herself. In this situation, personages from the analysand's representational world (Sandler and Rosenblatt 1962) may become unknowingly linked with presences in the analyst's mind. Invariably, however, for Jacobs an enactment and its successful analysis allow for the emergence and clarification of unconscious conflicts in the patient; thus, *an enactment is considered within the framework of the classically established goal of making the unconscious conscious.*

Like Jacobs, most American analysts have tended to view enactments as an avenue toward the goal of making unconscious conflicts in the patient conscious. Dale Boesky (1990) suggested an additional benefit of the analyst's being drawn into an enactment, in that it allows the analysand to sense the analyst's engagement with him or her: "If the analyst does not get emotionally involved sooner or later in a manner that he had not intended, the analysis will not proceed to a successful conclusion" (p. 573). Here Boesky is making an important point about the *patient's awareness of the analyst's countertransference:* whereas Money-Kyrle (1956) addressed the unconscious meaning the analysand gives to the perception of the countertransference, Boesky is additionally underscoring that the patient may find conscious reassurance in the clinician's emotional engagement. By the early 1990s, the role of the analyst's subjectivity in the analytic encounter was becoming an increasingly prominent area of study, and I now turn to this development.

Countertransference: The Analytic Field, Intersubjectivity, and a New Theory of Dreaming (1990–Present)

One of the criticisms of classical analytic technique (Mitchell 1998; Renik 1995) has been that it relied on the analyst as an "authority" figure who sifts through the analysand's associations to discover the hidden meaning and then offers interpretive pronouncements. Renik (1993) introduced the notion of the analyst's "irreducible subjectivity" to highlight the inevitable involvement of the analyst's personality in his or her interpretations, stating that insight is not a commodity given by the analyst to the patient but rather "that analytic truths are co-created by analyst and patient, rather than unveiled by means of the analyst's objective observations of the patient's projections" (Renik 2004, p. 1056). These comments, distilled from the study of the analyst's involvement in enactments, further shifted the concept of countertransference away from an artifact to be "sanitized" to an "irreducible subjectivity" and thereby promoted a diminished emphasis on the analyst's authority.

The theme of analyst and patient co-creating insight is closely allied to the exploration of the *analytic field* by other authors whose works are influenced by the writings of Klein and Bion (Brown 2011). These contributions derive from Kurt Lewin's (1935) formulation of *field theory,* in which he proposed that a dynamic field is created from the properties of the elements of that field but that the ultimate creation is greater than the sum of its parts. This idea was first applied to the study of group phenomena by Bion (1961), who observed that a collective unconscious fantasy may appear in a group that is an expression of a shared experience by the members. In a paper that was not published in English until recently, Baranger and Baranger (2008) of Argentina connected Bion's theory of groups to the two-person analytic situation and outlined what they call the *shared unconscious phantasy* of the therapeutic dyad:

> This structure [shared unconscious phantasy] cannot in any way be considered to be determined by the patient's (or the analyst's) instinctual impulses, although the impulses of both are involved in its structuring....Neither can it be considered to be the sum of the two internal situations. *It is something created between the two, within the unit that they form in the moment of the session, something radically different from what each of them is separately.* (p. 806, italics added)

This model of the analytic relationship adds a new dimension to our comprehension of countertransference: the analyst's emotional experience in the session is a conduit to a shared unconscious experience that is built from aspects of the patient and of the analyst. It is "something radically different from what each of them is separately," or put another way, it represents "something fascinating about the analytic intercourse; between the two of them, they do seem to give birth to an idea" (Bion 2005, p. 22). From this perspective, therefore, it is less important for the analyst to sort out "whose idea was it" (Ogden 2003b) than to regard countertransference as tuned into a shared emotional experience that the analyst and the patient, each in his or her own way, are attempting to come to terms with. Returning once again to Abraham's (1909) letter to Freud, I began the previous section by speculating that Abraham's looking at the picture of his parents for approval and his associations to his daughter's constipation may indicate that he was unconsciously resonating with some emotion stirred by his patient. If we add the perspective of the "shared unconscious phantasy," we may also consider the possibility that *both Abraham and his patient* were under the sway of an unconscious fantasy (i.e., a wish to receive parental approval and defiance against that authority) that permeated the communal analytic mood.

The literature on the analyst's and patient's mutual contribution to enactments, Renik's (and others) thoughts about the co-creation of meaning (insight) in the analytic pair, and the idea of a shared unconscious fantasy all fall under the umbrella of *intersubjectivity.* This topic is discussed in another chapter in this textbook, but it seems important to note that the study of countertransference appears to have been subsumed in recent years by investigations into the nature of intersubjectivity (Brown 2011). It is my impression that countertransference still carries a somewhat pejorative association; for example, countertransference dreams are not generally spoken about, and candidates are loath to discuss these in supervision (Brown 2007). On the other hand, the term *intersubjectivity* does not have the history of stigmatizing the analyst's feelings that countertransference has carried and instead normalizes the therapist's experience, however troubling it may be.

Before closing, there is one last perspective on countertransference that deserves attention: that *the analyst's experience of the analytic hour is a dream.* Bion (1992) expanded Freud's theory of dreaming (the reader is referred to Grotstein's [2009c] paper dealing with Freud's and Bion's dream theories) in which he asserted that we are always dreaming while awake and asleep. He viewed dreaming as the mind's way of processing raw emotional experience and giving it meaning with one's personal stamp. Ogden (2003a, 2004, 2007) has written extensively about Bion's views on dreaming and described how the analyst's waking dream thoughts (or reveries) are the means by which his or her psyches unconsciously transform experiences of the patient (conveyed to the analyst through projective identification) that are too unbearable for the analysand to "dream" on his or her own. Furthermore, not only is the clinician transforming an unmanageable emotional experience for the patient, but his or her waking dream thoughts are also "unconscious work" the clinician is doing to represent the shared unconscious fantasy active in the analytic hour.

The Italian analyst Antonino Ferro (2002, 2005, 2009) also placed great importance on the concept of "waking dream thoughts" in both the analyst and patient as indicators of the *analytic couple's fertility,* which is an important component of the analytic field and related to the question of analyzability: can this analyst–patient dyad engage in a mutual unconscious process that transforms unrepresented emotional experience? One offspring of the patient and analyst's unconscious interaction is the appearance of new *characters* in the patient's narrative that is a barometer of the aliveness in the analytic field. Ferro views the development of a jointly constructed narrative as the vehicle for transformation of the shared unconscious fantasy of the analytic field (Ferro 2009). He stressed that a chief task of the analyst is to adopt a stance of *transformational receptiveness,* which means that the analyst must be open to experience what the patient needs him or her to feel; only then can the analyst use his or her reverie function to give possible significance to the analysand's communications. Ultimately, analytic progress depends on "the deep emotional level of the couple, on which the projective identifications are used to establish the emotional foundation which needs to be narrated through the characters and transformed by working through, and which must be shared by way of a story" (Ferro 2002, p. 25).

Conclusion

This chapter traced the development of our current understanding of countertransference from its early roots when it was seen as an impediment to treatment (though useful to the analyst's self-analysis) to contemporary perspectives that consider it as an "instrument of the analysis." When viewed in the latter way, countertransference is an important tool to understanding the patient's unconscious through the analyst's identification with elements of the analysand's inner world. This identification is achieved by the patient's activity of using projective identification and the clinician's activity of taking in (introjecting) what is projected. The analyst's receptivity to the patient's unconscious communications is a vital but often difficult aspect of doing analysis. Furthermore, the patient looks to the therapist to give meaning to what he or she has unconsciously conveyed. However, we have seen an evolution in how the analyst's role is conceived as a giver of meaning through interpretation. More recent developments have emphasized the importance of the analyst being less an authority who delivers interpretive pronouncements and more a collaborator engaging co-creatively with the patient to jointly discover meaning, a process that in part relies on the use of the analyst's countertransference. In this connection, countertransference may be likened to dreaming in that the analyst's experience of the patient performs the function of transforming (dreaming) frightening emotions too unbearable for the analysand to manage (dream) on his or her own.

KEY POINTS

- Freud and his cohort tended to see countertransference as an impediment to treatment and was an unconscious reaction of the analyst to coming into contact with the patient's infantile neurosis.

- Although these classical analysts emphasized that the analyst should not permit his or her emotional reactions to distract from listening to the analysand, they also viewed self-analysis of one's countertransference as necessary in order for treatment to progress and stated that it could be a useful "instrument of the analysis."

- Subsequent contributions to the study of countertransference have, in essence, elaborated the ways that the analyst's subjectivity may be employed as an instrument of the analysis. In particular, Melanie Klein's concept of projective identification (and its extension by her followers) has been a vital tool in understanding how emotions evoked in the analyst may be meaningful communications from the patient.

- Other authors, notably Joseph Sandler and Theodore Jacobs, have explored the behavioral aspects of countertransference in which the patient subtly lures the analyst into an enactment. In this situation, the analyst may be unconsciously prodded into playing a role scripted by the analysand's inner object world; a role he or she is prone to adopt because of its resonance with aspects of the analyst's personality.

- More recent developments in our understanding of countertransference have been achieved through applying Bion's theory of dreaming to the analytic situation. The work of Thomas Ogden and Antonino Ferro has been essential in demonstrating the importance of the analyst's reveries as his or her unconscious activity by which unrepresented emotions that permeate the shared emotional field of the analytic dyad are "dreamed," that is, given affective significance created jointly by analyst and analysand.

References

Abraham K: Letter to Sigmund Freud, 7 April 1909 (1909), in The Complete Correspondence of Karl Abraham to Sigmund Freud. Edited by Falzeder E. London, Karnac Books, pp 86–88

Balint A, Balint M: On transference and counter-transference. Int J Psychoanal 20:223–230, 1939

Balint M: Analytic training and training analysis. Int J Psychoanal 35:157–162, 1954

Baranger M, Baranger W: The analytic situation as a dynamic field. Int J Psychoanal 89:795–826, 2008

Bernardi R: Letter from Uruguay. Int J Psychoanal 89:233–240, 2008

Bion W: Differentiation of the psychotic from the non-psychotic personalities. Int J Psychoanal 38:266–275, 1957

Bion W: On arrogance. Int J Psychoanal 39:144–146, 1958

Bion W: Attacks on linking. Int J Psychoanal 40:308–315, 1959

Bion W: Experiences in Groups. London, Tavistock, 1961

Bion W: Learning From Experience. London, Heinemann, 1962

Bion W: Brazilian Lectures: 1973 Sao Paulo; 1974 Rio de Janeiro. London, Karnac, 1990

Bion W: Cogitations. London, Karnac, 1992

Bion W: Taming Wild Thoughts. London, Karnac, 1997

Bion W: The Tavistock Seminars. London, Karnac, 2005

Boesky D: The psychoanalytic process and its components. Psychoanal Q 59:550–584, 1990

Brown LJ: On dreaming one's patient: reflections on an aspect of countertransference dreams. Psychoanal Q 76:835–861, 2007

Brown LJ: The ego psychology of Wilfred Bion: implications for an intersubjective view of psychic structure. Psychoanal Q 78:27–55, 2009

Brown LJ: Klein, Bion and intersubjectivity: becoming, transforming and dreaming. Psychoanalytic Dialogues 20:669–682, 2010

Brown LJ: Intersubjective Processes and the Unconscious: An Integration of Freudian, Kleinian and Bion Perspectives. London, Routledge, 2011

Ferenczi S: Letter from Sandor Ferenczi to Sigmund Freud, February 7, 1911 (1911), in The Correspondence of Sandor Ferenczi and Sigmund Freud, Vol 1, 1908–1914. Edited by Brabent E, Falzeder E, Giampieri-Deutsch P. Cambridge, MA, Belknap Press of Harvard University Press, 1993, p 253

Ferro A: In the Analyst's Consulting Room. New York, Brunner-Routledge, 2002

Ferro A: Seeds of Illness, Seeds of Recovery. New York, Brunner-Routledge, 2005

Ferro A: Mind Works: Technique and Creativity in Psychoanalysis. New York, Routledge, 2009

Fliess R: The metapsychology of the analyst. Psychoanal Q 11:211–227, 1942

Freud S: Fragment of an analysis of a case of hysteria (1905), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 7. Translated and edited by Strachey J. London, Hogarth Press, 1953, pp 7–122

Freud S: Letter to Sandor Ferenczi, October 22, 1909 (1909), in The Correspondence of Sigmund Freud and Sandor Ferenczi, Vol 1, 1908–1914. Edited by Brabent E, Falzeder E, Giampieri-Deutsch P. Cambridge, MA, Belknap Press of Harvard University Press, 1993, pp 84–86

Freud S: The future prospects of psycho-analytic therapy (1910), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 11. Translated by Strachey J. London, Hogarth Press, 1957, pp 139–151

Freud S: Letter from Sigmund Freud to C. G. Jung, December 31, 1911 (1911), in The Freud/Jung Letters: The Correspondence Between Sigmund Freud and C. G. Jung. Edited by McGuire W. Princeton, NJ, Princeton University Press, 1974, pp 475–476

Freud S: Recommendations to physicians practicing psychoanalysis (1912), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 12. Translated and edited by Strachey J. London, Hogarth, 1958, pp 109–120

Freud S: Letter to Ludwig Binswanger, February 20, 1913 (1913), in The Sigmund Freud-Ludwig Binswanger Correspondence 1908–1938. Edited by Fichtner G. New York, Other Press, 2003, pp 112–113

Freud S: The ego and the id (1923), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 18. Translated and edited by Strachey J. London, Hogarth Press, 1961, pp 3–66

Freud S: Inhibitions, symptoms and anxiety (1926), in The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 20. Translated and edited by Strachey J. London, Hogarth Press, 1959, pp 77–174

Glover E: Lectures on technique in psycho-analysis. Int J Psychoanal 8:311–338, 1927

Grinberg L: The Goals of Psychoanalysis: Identification, Identity and Supervision. London, Karnac, 1990

Grotstein J: Dreaming as a "curtain of illusion": revisiting the "royal road" with Bion as our guide. Int J Psychoanal 90:733–752, 2009c

Heimann P: On counter-transference. Int J Psychoanal 31:81–84, 1950

Isakower O: Preliminary thoughts on the analyzing instrument (1957). J Clin Psychoanal 6:184–194, 1992

Isakower O: The analyzing instrument: states of consciousness and the dream psychology of Dr. Bertram Lewis (1963). J Clin Psychoanal 6:204–215, 1992

Jacobs T: The analyst and the patient's object world: notes on an aspect of countertransference. J Am Psychoanal Assoc 31:619–642, 1983

Jacobs T: The Use of the Self: Countertransference and Communication in the Analytic Situation. New York, International Universities Press, 1991

Jacobs T: Review of "The metapsychology of the analyst" by Robert Fliess. Psychoanal Q 76:715–724, 2007

Joseph B: The patient who is difficult to reach (1975), in Psychic Equilibrium and Psychic Change: Selected Papers of Betty Joseph. Edited by Feldman M, Spillius E. New York, Routledge, 1989, pp 75–87

Kernberg O: Notes on countertransference. J Am Psychoanal Assoc 13:38–56, 1965
Kernberg O: Borderline personality organization (1967), in Borderline Conditions and Pathological Narcissism. New York, Jason Aronson, 1975, pp 3–47
Klein M: Notes on some schizoid mechanisms (1946), in Envy and Gratitude. London, Hogarth Press, 1975, pp 1–24
Lewin K: A Dynamic Theory of Personality. New York, McGraw-Hill, 1935
Lothane Z: Reciprocal free association: listening with the third ear as an instrument in psychoanalysis. Psychoanal Psychol 23:711–727, 2006
Mitchell S: The analyst's knowledge and authority. Psychoanal Q 67:1–31, 1998
Modell A: Self preservation and the preservation of the self. Ann Psychoanal 12:69–86, 1984
Money-Kyrie R: Normal counter-transference and some of its deviations. Int J Psychoanal 37:360–366, 1956
Ogden T: On not being able to dream. Int J Psychoanal 84:17–30, 2003a
Ogden T: What's true and whose idea was it? Int J Psychoanal 84:593–606, 2003b
Ogden T: This art of psychoanalysis: dreaming undreamt dreams and interrupted cries. Int J Psychoanal 85:857–877, 2004
Ogden T: On talking-as-dreaming. Int J Psychoanal 88:575–589, 2007
Pick IB: Working through in the countertransference. Int J Psychoanal 66:157–166, 1985
Racker H: A contribution to the problem of counter-transference. Int J Psychoanal 34:313–324, 1953
Racker H: The meanings and uses of countertransference (1957), in Transference and Countertransference. New York, International Universities Press, 1968, pp 127–173
Reik T: Some remarks on the study of resistances. Int J Psychoanal 5:141–154, 1924
Reik T: Listening With the Third Ear: The Inner Experiences of a Psychoanalyst. New York, Grove, 1948
Renik O: Analytic interaction: conceptualizing technique in light of the analyst's irreducible subjectivity. Psychoanal Q 62:553–571, 1993
Renik O: The ideal of the anonymous analyst and the problem of self-disclosure. Psychoanal Q 64:466–495, 1995
Renik O: Intersubjectivity in psychoanalysis. Int J Psychoanal 85:1053–1056, 2004
Rickman J: Reflections on the function and organization of a psycho-analytical society. Int J Psychoanal 32:218–237, 1951
Ross WD, Kapp FT: A technique for self-analysis of countertransference: use of the psychoanalyst's visual images in response to patient's dreams. J Am Psychoanal Assoc 10:643–657, 1962
Sandler J: Countertransference and role-responsiveness. Int Rev Psychoanal 3:43–47, 1976
Sandler J, Rosenblatt B: The concept of the representational world. Psychoanal Study Child 17:128–145, 1962
Schafer R: On "The metapsychology of the analyst" by Robert Fliess. Psychoanal Q 76:607–714, 2007
Spillius E: Melanie Klein revisited: her unpublished thoughts on technique, in Encounters With Melanie Klein: Selected Papers of Elizabeth Spillius. Edited by Birksted-Breen D. New York, Routledge, 2007
Winnicott W: Hate in the countertransference. Int J Psychoanal 30:69–74, 1949
Wyman HM, Rittenberg SM: The analyzing instrument of Otto Isakower, M.D.: evolution of a concept. J Clin Psychoanal 1:165–316, 1992

7

Defense and Resistance

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DEFENSE AND RESISTANCE are closely allied concepts. *Defense* refers to the means by which the mind unconsciously protects itself from danger from within and without. *Resistance* refers to the operation of defense within the analytic situation. The progression of analysis entails a deepening process for both analyst and patient: the patient's inner world of fantasies and feelings gradually becomes focused on the figure of the analyst while the patient comes into contact with previously inaccessible aspects of that inner world, and the analyst's own inner world comes alive as well in the service of coming to understand the patient. Resistance reflects the ways by which patient and analyst oppose and manage this deepening and the dangers that arise from it. The interpretation and working-through of resistance is a central aspect of analytic work and makes a major contribution to the lasting change that analysis may produce.

Because the analytic situation involves two participants and generates a process unique to the pair, resistance may be viewed from several different perspectives. From the perspective of one-person psychology—the understanding of the patient as a single individual—resistance may be seen as the way the patient mobilizes defenses in order to manage the wishes and anxieties that arise in analysis. From the perspective of two-person psychology—the understanding of the way the individual minds of analyst and patient interact—resistance may be seen as the way each participant uses the other in order to manage dangers that arise to that individual: the way the patient engages the analyst to ward off danger and, less frequently, the way the analyst engages the patient to do the same. From the perspective of the analytic field—the understanding of the way patient and analyst function together as an analyzing unit—resistance may be seen as the way the analytic pair manages and controls threatened disruptions to the pair's equilibrium. These perspectives are not mutually exclusive, and each can contribute to our understanding of the complex dynamics of the analytic process.

Pioneering Contributions

Both the concept of defense and the concept of resistance originate in the work of Freud. In his 1894 paper "The