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Contemporary transference work and the analytic attitude

Aims and methods - a clinical workshop

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analytic attitude, contemporary transference work

There are various ways of working as an analyst, and there are various ways of utilizing the concept and the phenomena of transference-countertransference. I hope to draw an adequate picture of a way of working that is called 'working-in-the-transference' as distinct from ways of working that 'analyse transference'. The former has long been practised by many Jungians as well as by many psychoanalysts. As a method, it has aroused controversy in both groups, and is frequently both misunderstood and imitated. It can arouse strong anxiety. It can appear narrow and restrictive. It famously precludes a gamut of activities in which many analysts engage. Is working-in-the-transference old fashioned, or does it deserve to be increasingly appreciated? Can it offer support and validation whilst remaining true to its conception? It was hoped that these questions would be addressed in the clinical material brought to the workshop.

The emphasis in the workshop was on active participation and it was hoped that those attending would bring their clinical concerns for discussion.

In the workshop I presented, I wanted to try to show something of how the use of the transference as a central philosophical and emotional orientation in analysis is not only appropriate, but also how I see it as being compatible with Jungian perspectives.

Jung himself considered the transference, notwithstanding his unconcealed anxiety about methodically analysing the transference himself, to be 'the alpha and the omega of analysis' (Fordham 1974). He asserted that '[t]hanks to this personal feeling Freud was able to discover wherein lay the therapeutic effect of psychoanalysis' (Jung 1913, 'The theory of psychoanalysis', *CW* 4). As in many other areas Jung was 'ahead of his time' when he considered that transference entailed much more than just the sexual area, as was thought by Freud at the time. Jung said that there are 'moral, social and ethical components', a view that seems nearer to Melanie Klein's much later conception of the transference as

the *total situation* than to Freud's view in that period. He observed, for example, that the patient may bargain with the analyst like a

child who wishes to get special favours from his parents, or may seek out 'special adventures', which the analyst must not prevent since they may contain value for the patient. 'We have to let the patient and his impulses take the lead' (Jung 1913, in Fordham 1974). He saw the sexual fantasies as analogies related to empathy, adaptation and 'the urge towards individualization'. Jung saw that both negative and positive transference furthered 'individualization' (Jung1914, CW4, in Fordham 1974.)

Michael Fordham noted that Jung described transference to have 'biological value' as 'a bridge across which the patient can get away from his family into reality'. Jung also thought that the infantile elements of the transference represented a 'powerful hindrance to the progress of the treatment because the patient assimilates the analyst to his father and mother', and the more he does this, so much more will transference do him harm (Jung 1913, quoted in Fordham 1974, Jung's 'Conception of the transference'). Fordham observed that although Jung credited Freud with the discovery that the transference itself is the therapeutic factor in analysis, it appears to have been Jung's view, while the Freudians at that time seem to have believed that improvement lay in making unconscious contents conscious. Fordham (1974) wrote:

> *Jung went along with Freud in recognizing the incestuous, erotic and infantile characteristics of transference, as well as accepting its resistance phenomena. Where he went beyond psychoanalysis is in his emphasis on the goal-seeking and therapeutic function of transference in which the real personality of the analyst became highly significant. His emphasis on transference as a potentially therapeutic situation and on the real personality of the analyst seems to have been his own particular contribution. The idea that once the projections have been recognized and resolved, a bridge to reality can be made with the aim of attaining moral autonomy, defined, even in 1913, as the 'urge towards individualization', is characteristic and central in the development of his thesis. The social and religious, moral and ethical meanings of transference are also much more important to Jung than to Freud.*

It seems to me that a consideration of the importance of the transference/countertransference 'situation' in the analytic process would be served by first thinking about some of the aims of analysis. Then I would like to say something

about how the transference/countertransference may be used in the furtherance of these aims. (I consider the two, transference and countertransference, to be interdependent parts of the same process, but I will refer to the process only as ‘the transference’ henceforth.)

In my view, analysis provides a type of emotional relationship that cannot be found elsewhere. It is an experience of extra-ordinary intimacy and meaning, expressly of a non-enacted and non-erotic kind. Significantly, it is in the context of the relationship itself that new developments take place in the psyche (and accordingly in the brain.)

This relational model of the analytic process is analogous to an early mother-infant couple, in which existing infantile parts of the psyche, including the propensity to form archetypal images, are brought to the fore and primitive

emotional experiences and defence systems and their attendant imagery are re-experienced and re-worked in the relations between the patient and the analyst. Thus it is by means of the relationship that the opportunities exist for the alleviation of mental disturbance, the recovery of lost parts of the self, and progressive emotional growth and development. I submit that these are amongst the foremost aims of analysis and are inextricably linked with the analysis of the transference.

In the early days of psychoanalysis, Freud thought the therapeutic action of psychoanalysis to be in the uncovering of unconscious conflicts and educating the patient to them. This ‘suggestion’ method offered the patient intellectual knowledge but not psychic change. It was replaced when Freud recognized the importance of transference phenomena, first as resistance, then necessity, and then as therapeutic instrument. At first the salutary effect of the transference was believed to lie in the induction in the patient of strong positive emotional ties to the analyst. The dangers of this practice were soon realized. The analyst was ‘omnipotently’ controlling the patient, and the patient the analyst. Negative and erotic transference material appeared. The ‘insights’ were again short-lived.

Once understood, this impasse led many analysts to investigate the process whereby lasting psychic change takes place. The analysis of the nature of the transference, its unconscious roots, its reflections in symptoms, in dreams, in the vicissitudes of emotional life and consequently the ego (especially in the area of symbolization and thinking) - all seen in the ‘here and now’ - ultimately took its place at the centre of the procedure. Meaning and feeling lay at the

centre of the transference, in the drama that is always taking place in the inner world.

This was a major advance. The analyst was no longer an ‘omnipotent’ and ‘omniscient’ figure, but rather someone who reverberated emotionally at a very deep level whilst remaining aware of the dangers of unconsciously taking part in the internal drama. (Racker [1968] described this latter as ‘identifying with the inner object’.) The countertransference and its manifestations became an important area of study in itself. Racker, Heimann, Money-Kyrle, Fordham and many others gave much attention to the various forms that countertransference may take and how it may be worked with to think about the transference. Bion (1977) advanced the thinking about the analyst's position in his thoughts on memory, desire and understanding as qualities to be eschewed in the approach to an analytic session.

Refraining from the imposition of one's own views and the projections of one's own emotional life into the patient was of the highest priority. The impulse to reassure, advise, praise, or otherwise gratify was noted as counterproductive. Humility and modesty were essential qualities of the analyst. Freud referred to the comment of the seventeenth century surgeon, Ambroise Paré, ‘*Je le pansai, Dieu le guérit*’ (I have dressed his wounds, God healed him). For a Jungian analyst, the self, with its integrating and life-affirming qualities, is an ally in the analytic process.

Two further developments that have established their place in modern transference analysis stem directly from Melanie Klein. First is the observation that the unconscious relations being played out in the transference are not merely the re-playing of long-past emotional life, but living, present experiences taking place in the inner world and changing all the time. Secondly, this came to be best understood through the interplay of projection and introjection between the patient and his objects, notably in the action of projective identification. In James Strachey's phrase, the analyst is an ‘external phantasy object’ (Strachey 1934, quoted in Caper 1999, p. 20).

I shall offer two clinical vignettes that I hope will illustrate some of these points.

Patient 1:

Mrs X is an intelligent and highly successful businesswoman in her fifties who recently separated from her husband of twenty-five years. A colleague, who

works as a counsellor in a general practitioner's surgery, referred her ostensibly because of nervous states at work that had resulted in various somatic complaints. She told me that she had suffered from a range of severe phobias all her life, which now interfered with her daily activities. She also told me that she felt unloved and unloving all her life, apart from the love she feels for her now grown daughter. Mrs X described her relationships with her parents as cold and lacking emotional understanding. She has one sister who believes that she is possessed by the devil and has regular exorcisms. It was evident quite early on that, amongst other difficulties, my patient had little capacity for recognizing or naming her own feelings.

She agreed readily to attend three times weekly and decided to use the couch when I offered it. Soon she was talking quite freely and trustingly, seemingly taking to the process like a duck to water. She developed mainly positive feelings towards me, particularly after my first interpretation of a dream, which she found very moving. Soon she was reporting dreams regularly and freely telling me of the events taking place in her mind and in her external world. In fact what appeared to be the case was that she felt listened to and understood - virtually for the first time in her life.

She felt ‘supported’ and strengthened very early on. In the first year of her analysis, she became divorced, her mother died, she moved house and she left her long-term job as a business executive to start a freelance consultancy.

The patient found surprisingly soon that her states of panic when driving on motorways and when going across bridges, into lifts and tall buildings, to name only a few, diminished in frequency and intensity. She felt that I understood her and that I was emotionally available for her. All of this contributed to corresponding feelings in me that I was an effective and appreciated analyst who therefore needed to take care not to encourage a split in her feelings between her ‘bad’ parents and myself.

These apparent changes in her proved to be superficial, as was my hubris, and belied deep insecurities in the patient. At times she requested, because of an important meeting at work or another equally ‘serious’ reason, a change in the time of her session, or needed to cancel one of her sessions. With every disturbance of the analytic framework the patient suffered serious depression and emotional setbacks. My own feelings of being a good analyst soon evaporated. Breaks, especially the longer ones, were traumatic. We came to see that the more important element was not the ‘correctness’ of my interpretations but the question of her overriding need for me to be there for

her, keeping the framework steady. Her word for it was that she felt ‘supported’. When I was there and analysis was uninterrupted, she felt that ‘God's in His Heaven, all's right with the world’. In my absences, the very opposite experience prevailed. Through this material, her dreams and my thinking about my own feelings in being either a wonderful or a terrible analyst (either way being neither a real nor an ordinary analyst), we found that she suffered such profound rage and such disappointment that I could be absent or ‘unreliable’ that she ‘wiped me out’ and lost me in internal as well as in external reality, at those times. Yet it was the emotional experience of an analytic relationship that she could in reality genuinely depend upon, even when she was angry and disappointed in the relationship, that enabled her, perhaps for the first time in her life, to relinquish her ‘self-reliance’ that had always obviated the need for emotionally significant relationships. This led to her beginning to be able to bear her dependency on good objects, to acknowledge their importance and to mourn her losses. If I were to link all this too quickly and too ‘knowingly’ with her early emotional needs and deprivations, she would have viewed this as yet another ‘understanding’ interpretation, but it would have been one of many that did not offer the possibility of real psychic change.

Patient 2:

Here is an example of the projective identification process, and how it can facilitate the analyst in his understanding.

My patient, Miss Y, in five-times-weekly analysis, was silent for the first few minutes on a Monday morning. She said she had had a lot to say but now nothing will come. After a while she said that over the weekend she had had a horrible telephone conversation with her former husband, who had been psychotic and an alcoholic. He had obtained her telephone number from a mutual friend. She hadn't heard from him in a long time. He was drunk and very aggressive, pleading and arguing with her to come back to him. He said that she broke her marriage vow that she would stay with him forever.

My patient fell silent for a long time. I asked her what she was thinking, She said, ‘Nothing. I have no thoughts’. I asked her what she was feeling. She replied, ‘Peaceful’. She wept silently. I began to feel helpless and useless. I felt sleepy. Although she felt ‘peaceful’, I now felt that I had abandoned her and

was leaving her in something terrible. Yet I did not want to say something just to break the silence and 'make her feel better'. I felt it was important for her to take responsibility for the state she was in and for us to see what came out of it. This led me to say after a short while that she felt quite helpless and that she wanted me to know what it was like to be faced with someone in distress and to be unable to help. I said that her feeling of helplessness made her lose her thoughts.

She replied with a number of thoughts about her husband and her original family, whom she left 'in a mess that [she] could not clear up' to go and live in another country. She felt terribly guilty and bad. But now she thinks that her husband, like her family, must take responsibility for his own difficulties, rather than her taking them on. (She has done that with others all her life.) She added that she feels now that they must take responsibility for the wish to make things better for themselves, rather than her carrying that wish for them.

The concept of the transference has changed greatly from what was first seen by Freud as an impediment to analysis (as, for example, when a patient threw her arms around him), then as resistance to be analysed, only to evolve much later into the central tool of analysis. Jung expressed varied and ambivalent feelings about the analysis of transference phenomena, and seemed to feel in awe of its power. He often asserted the view that the transference should be resolved so that analyst and patient can get on with the 'real' relationship and work on individuation. In the early days of psychoanalysis and analytical psychology, 'patients' were seen mainly to be transferring the person of the external object, the actual figure, onto subsequent relationships. A major change in the concept was inaugurated by James Strachey, who observed that it was not the external objects that were transferred but their inner world counterparts, the internal objects, and that this conditioned patients' views of the world. He suggested that understanding the way these inner objects are constructed enables the analyst to promote inner change. Later, Melanie Klein, whose interest and studies throughout her working life were in the area of early emotional experience, soon after her elaboration of the concept of projective identification, described something she called 'the transference situation'. She wrote, 'It is my experience that in unravelling the details of the transference it is essential to think in terms of *total situations* transferred from the past into the present, as well as emotions, defences, and object relations' (Klein 1952, 'The origins of transference'). Betty Joseph (1985, and in *Melanie Klein Today*) wrote:

> *She went on to describe how for many years transference had been understood in terms of direct references to the analyst and how only*

later had it been realized that, for example, such things as reports about everyday life, etc. gave a clue to the unconscious anxieties stirred up in the transference situation. It seems to me that the notion of total situations is fundamental to our understanding and our use of the transference today ... By definition it must include everything that the patient brings into the relationship. What he brings in can best be gauged by our focusing our attention

on what is going on within the relationship, how he is using the analyst, alongside and beyond what he is saying. Much of our understanding of the transference comes through our understanding of how our patients act on us to feel things for many varied reasons; how they try to draw us into their defensive systems; how they unconsciously act out with us in the transference, trying to get us to act out with them; how they convey aspects of their inner world built up from infancy - elaborated in childhood, experiences often beyond the use of words, which we can often only capture through the feelings aroused in us, through our counter-transference, used in the broad sense of the word.

The author is telling us that to a very great extent the transference is now thought about and interpreted through the workings of projective identification. Everything that occurs verbally and non-verbally - action, inaction, the order and style in which the patient presents what he presents, the symbolic content of the words - in short the total situation, is taken into account in the analyst's reflections. Bion and others identified and refined various forms of projective identification, not only defensive or 'pathological' but also 'normal projective identification', for communication. The latter form promotes 'healthy' emotional development when the communications are adequately received and transformed into a form that can be 'thought about'. It is related to, but not identical to, the process of de-integration and re-integration of the archetypes in emotional development.

These various forms of projective identification can be seen from earliest infancy as well as in the analytic process. Studies in infant observation have contributed materially to our understanding of their operation.

There is an important distinction between 'analysing the transference' and 'working in the transference', in my view. The former is a method in which, along with placing emphasis on a number of different areas as part of the

analytic process, transference is spotted and perhaps interpreted or referred to, or perhaps just made a mental note of. Working in the transference, by contrast, refers to the use of the transference as the central orientation in the analytic method, a practice that is predicated upon the belief that virtually all the material brought to the analytic session, whether verbal or non-verbal, whether dreams or free associations, communicate something about the on-going inner relationship between the patient and the analyst. Incidentally, the relationship between the patient and the analyst is not viewed as of greater importance than other relationships, past and present, but the idea is that the analysis of that relationship 'gathers in the transference' from relations in the external and internal worlds into a 'place' where it can be thought about. It is the meaningful relationship in the consulting room, in the 'here and now'.

I am aware that my remarks about transference work may well seem to apply strictly to four-or five-times weekly analysis, in which there is greater containment of the emotional experience of the patient than in less frequent psychotherapeutic work. I believe that these same principles apply whatever the frequency of the work, although this may dictate the nature of the interpretations.

Much consideration is given to how and when one interprets the transference, which requires skill and forbearance as well as courage and conviction. The subject of interpretation is a very large one that requires much consideration. One works somewhat differently with patients who come less frequently than with those who come for daily analysis. In the first case, the transference often has to be kept in mind to a greater extent, rather than necessarily be interpreted openly or in the same way. Undoubtedly one also works differently with different patients. Nevertheless the same basic principles apply.

One thing I have found, though, is that with supervision, analysts who thought they could only work once or twice weekly with patients may discover in themselves and in their patients' material that they both want to work more frequently. Anxiety, for both the analyst and the patient, about working so closely and with such emotional intensity is very often the inhibiting factor when on the surface reasons such as time and money have been given by the patient and accepted readily by the analyst.

Those who work 'in the transference' place considerable importance on waiting for the material to unfold and avoid doing anything that may change its direction. This means that the patient has a minimum of information about the reality of the analyst's life and background, nor about his internal life directly,

except that very deep aspects of himself are engaged in his relation to the patient. There must be, moreover, an absence of social or any other contact between the patient and the analyst outside the session. The method also entails special handling by the analyst of all things that arise in the session, whether they are questions that the patient asks (and the way in which he does it), requests, actions, attempts at physical contact, as well as the analyst's private emotional responses. Everything that arises has potentially great meaning in the transference relationship and can potentially inform the analyst as to ‘what is going on’ in inner object relations.

This method seeks to avoid stimulation through any thing other than the inevitable person of the analyst, such as painting or other means of expression, or bringing things to the room. (This is different in the case of child analysis, for special reasons. For one thing, young children are less verbally adept and may use the toys and other materials provided in the way that an adult may use verbal association.) Physical contact of any sort whatsoever with patients may have vast repercussions in unconscious life. So have any actions into which the analyst may be drawn. One patient tried to persuade me to buy her husband's nearly new car at a knockdown price. Another offered gifts. Still another invited me to use his film star friends' ski house in Switzerland. As will be apparent, the analyst who works in this way, ‘in the transference’, leads a working life of deprivation and self-denial, in a sense. It is also a deeply enriching and rewarding one. The relationship he is offering the patient is very quickly understood as unlike any other, and clearly not a social or a parental one. It is asymmetrical in the absence of all personal information about the analyst. The analyst does not spontaneously say anything that comes to mind, unlike the

patient. That does not by any means connote that it is lacking in meaning and intimacy. It is quite the contrary, and patients are not slow to understand this. Neither need it, in my experience, exclude spontaneous warmth and humour.

This rather rigorous and disciplined approach has as its basis what is called ‘the analytic attitude’ which has been accused of being cold, unfeeling or ‘inhuman’. Caper writes,

> *While it may seem that the analyst's lack of responsibility for whether or not his interpretations heal the patient is a rather cold and inhuman attitude, and perhaps even an irresponsible one, I would argue that precisely the opposite is true - that only by resisting the urge to achieve a cure with an interpretation can the analyst discharge*

his primary responsibility to the patient, which is not to heal him, but to help him recover himself.

In the long term, this approach brings great relief to patients, even, or rather especially, to more disturbed ones. I believe that this sense of relief arises from the patient's gradual recognition of the analyst's single-minded, even-handed focus on the business at hand, which is to see what is active in the patient's unconscious at the moment, and why. The effect of this is to relieve the patient of a profound anxiety that his inner world cannot be explored realistically, in a balanced way, without evasion, splitting, or the need to fix it immediately (Caper 1999, *A Mind of One's Own*, p. 26).

Caper also addresses the question of the transference relationship versus the 'real' relationship, to which Jung referred so often and which patients not infrequently feel is lacking in their analysis.

While the healthy part of even disturbed patients feels relief and gratitude at the analyst's ability to bear the patient's projections (as manifested by his ability to do no more than calmly interpret all aspects of his patient's unconscious), a disturbed part of even healthy patients feels that the analyst's exclusive commitment to even-handed interpretation is nothing more than pointless, artificial device. This part of the patient seems to regard transference figures that act out their roles as external phantasy objects as absolutely real, and the real figure of the analyst as artificial ... What leads the patient to feel the analytic relationship is artificial is, paradoxically, the analyst's very insistence on being real - his careful avoidance of the manifold collusions with the patient's unconscious phantasies that the patient expects of him in his role as an external phantasy object ... It is therefore quite important to keep in mind, when the patient feels that one is being 'real' and empathic, that one may be unwittingly colluding with the patient's perverse attack on the analyst's, and his own, reality sense.

What is Jungian about this perspective on the transference? I believe, along with Jung in 1913, that the transference relationship has a prospective and developmental function. Might we be permitted, even, to say that the transference is an archetype? It would seem to me to have all the characteristics. As such, it is a function of the self. Let us remember that Jung said that the transference showed all the stages of individuation.

One of Melanie Klein's contributions to the Freudian metapsychology was her introduction of the concept of an inner world in which 'something is always

going on’. Informed by the primitive perspectives of early life, the inner world is as ‘real’ a world as the outer one. It is ‘inner reality’. It is seen metaphorically as a ‘space’, where relations are continually taking place between the subject and his/her objects. These inner figures are effectively archetypal in their quality and their impact. Jung, too, saw the unconscious as a world of figures, quite in distinction to the psychoanalytic thinking of the day. He seemed to understand that what took place there was not mere ‘fantasy’ but rather a level of reality that governs our thinking and our behaviour. Both Jung and Klein ‘told stories’ as Michael Fordham said on a number of occasions.

The tension between negative and positive transference phenomena constitutes a balancing of opposites that is always present. It is one of the fulcrums of analytic work in this way. It was expressed by the psychoanalyst W. R. Bion in his formulation that the paranoid-schizoid and the depressive positions are always in dynamic tension and that is where the enormous energy of vital life forces is. One of Bion's (1977) major formulations is that there is, in one way or another, an inner relationship between what he called the contained and the container, the self and the other. It is in this relationship that unbearable states of mind are made suitable for thought; they are made bearable. They have ‘names’. In the absence of a good container-contained relationship, there is Nameless Dread. Catastrophic anxieties expand infinitely into space. This can be seen in dreams, for instance. In the infant's mind, originally, the container is in the mother's capacity for thinking about her baby's experience and the contained is the emotional life of the subject, the baby. This has numerous permutations and ramifications. For one thing, it provides, retrospectively, meaning to the therapeutic effect of the analytic relationship. The container-contained relationship is also a concept of Jung's although expressed in different language and a different context. The present idea is perhaps closer to Jung's metaphor of the *vas*, the alchemist's vessel in which transformations take place. As with many of Jung's ideas, here was a profound concept that contained the basis of something that was to be described later on in terms of object relations by clinicians with an interest in emotional development. Projective identification is another of those concepts that can be found in Jung in another form or other words, yet which show his emotional understanding of the later (in this case Kleinian) concept.

What about symbols? In my view, symbols arise within, and may perhaps most effectively be integrated into emotional life through the analysis of the profoundly meaningful ‘I-Thou’ relationship. Symbols are present not only in a patient's dreams; they exist perhaps ubiquitously, in all the material of the session, and in all of the analysis. Dreams are taken as part of the whole analytic picture, in the context of the anxieties and the defence systems that are

of most immediate relevance. Dreams, therefore, are understood in the transference at least as much as the transference is to be understood in the dream.

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There is an oft-heard opinion that it should be possible to find all the ideas we need within our own theories. This is not confined to our own group. However I am more of the opinion of a younger colleague, who experienced the following when she attended a group that was composed of students from the different schools, for a case presentation. Someone she met there told her that he had never met a Jungian before and he wondered why she was there. She answered that she feels the analytic community is like a multi-cultural society; the individual members do not have to lose their identities when they find they can benefit from what others outside their own group have to offer them.

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