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Countertransference and the analytic instrument

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«Perché nostra colpa sì ne scipa?»
[Why does our guilt waste us so?]
(Dante, *Inferno*)

Morris Eagle (2000) argued against recent trends that equate countertransference with anything and everything an analyst thinks and feels about a patient. He argued against the idea that countertransference is always a reliable window on the unconscious life of the patient. And he argued against a concept of projective identification in which a patient is presumed able to (quite literally) take something out of her/himself and put it into the analyst instead. He suggested that it would be useful to make a clear separation between: A) the kind of countertransference (the "classical" view) that impedes analytic work; and, B) the constructive use of the analyst's internalized representations of the patient ("trial" identifications) that build empathic resonance and thus serve the positive interests of the analysis. If we don't call this a form of countertransference, what should we call it? Eagle does not say. Calling it "the analytic instrument" seems to me a good way to characterize it. That term differentiates the concept from the conscious intellectual work done by the analyst, and it has utility as a descriptive kind of shorthand for an aggregation of complex phenomena.

Eagle gave us an important introductory statement in his paper, and I intend to address some of those issues in greater dynamic detail and, then, to expand upon them. There will be no review of the literature on either countertransference or enactment here because many very excellent and thorough reviews are quite readily available. After a discussion of the evolution of the concept of countertransference, an evolution complicated by the different and sometimes contradictory meanings Freud gave to the concept, I will amplify Eagle's position by spelling out in a clinically precise way some of the differences between: A) compromised behavior of the analyst that damages the integrity of the transference neurosis; B) compromised behavior of the analyst that has little or no effect on the organization of the transference neurosis; and, C) why making that distinction matters. Using that as a jumping off point I will then, in a formal way, introduce and elaborate the concept of "the analytic instrument" (not to be confused with Isakower's concept of the analyzing instrument, which I will discuss later). I will describe (in considerable dynamic detail) some of the ways that an analyst uses both conflicted as well as unconflicted aspects of his/her inner life in order to: A) build an intensely vital internal representation of the patient; and, B) identify aspects of the transference that have not yet been consciously recognized by either analyst or patient. In this view problematic internal states of the analyst do not necessarily lead to analytically destructive acting out and, although this seems paradoxical at first glance, they can

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sometimes be exceptionally constructive and even necessary for an analysis to progress. This is, however, in no way to be taken as an endorsement for countertransference or for intentional enactment on the part of the analyst. Countertransference is a prime example of this and, in fact, it may be no exaggeration to suggest that countertransference is one of the most variably defined concepts in all of psychoanalysis (seeming to undergo change almost daily, if not minute-by-minute). Samuel Stein (1991) describes this in an amusing way in a paper titled: "The Influence of Theory on the Psychoanalyst's Countertransference." He writes: "If candidates at the time I trained confided that they felt confused in a session, felt they were unable to think or even felt they were going mad, I doubt whether they would have been allowed to continue the course...Today if an analyst does not report disturbed countertransference reactions, suspicions may be aroused about the functioning of that analyst. Reports about 'not being able to think', 'feeling profoundly confused', are now a sign of the analyst's potency. It means that the analyst is able to be exposed to, and contain, the deepest anxieties and confusion from the patient. I expect and get reports of this kind regularly (and) I do not believe that analysts have changed. The changed countertransferences are due to changed theories." (p. 328).

Stein is quite correct in pointing out that the transference-countertransference matrix is now considered to be one of the most central features of the entire psychoanalytic undertaking. However, it is both paradoxical and disturbing that there is so little common agreement about something, or at least half of something, that is thought to be so critical in the psychoanalytic clinical process. Freud originally thought that countertransference was a resistance of the analyst that acted as an obstacle to the treatment, and many analysts are content to retain that view of it. Other analysts have rendered that original definition unrecognizable by viewing countertransference as a positive development and as an essential tool without which analysis would be impossible.

The difference in these starkly contrasting points of view depends, in part, on whether or not one includes the analyst's internal emotional processes and reactions along with his enacted behaviors in the clinical setting; and, if one includes the former, one's willingness to consider either a narrow range or a broad range of the analyst's internal processes in the definition of countertransference. I believe that collapsing together all of the analyst's internal processes, and then further collapsing this together with the analyst's behavior in the clinical setting itself, obscures the differences between what the analyst contributes to the psychoanalytic process that makes it work well, and what the analyst contributes to impede the analytic process. Therefore, I would like to suggest a sharpening of the distinctions between countertransference as an impediment to the process and a different concept, *the analytic instrument*, as a facilitator of it.

The compounding of countertransference, empathy, and intuition may be traceable to how they touched upon one another in Freud's mind as he developed his ideas about these processes. In 1910 Freud wrote: "We have become aware of the 'counter-transference', which arises in [the analyst] as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize this counter-transference in himself and overcome it." He went on: "[W]e have noticed that no psychoanalyst goes further than his own complexes and resistances permit; and we consequently require that he shall begin his activity with a self-analysis and continually carry it deeper while he is making his own observations on his patients. Anyone who fails to produce results in a self-analysis of this kind may at once give up any idea of being able to treat patients by analysis" (pp. 144-145). Did Freud mean that analysts always have a vast potential reservoir of inappropriate unconscious reactions toward their patients, based on their own neuroses, that inevitably disrupt analytic comprehension? Or was Freud thinking about a subset of the analyst's reactions, specific reactions that are prompted in direct relation to the different nature of each patient's transference demands?

In 1914 Freud described the potential for damage to the treatment that exists were the analyst to return in kind the patient's transferential love; and, Freud insisted (p.170) that the analyst always has a fundamental necessity to struggle "in his own mind against the forces which seek to drag him down from the analytic level." When Freud focused on the analyst's being dragged down from the analytic level his

emphasis seemed to be on how the analyst's conflicts could cause him to act something out with the patient, an action in the treatment prompted by some inappropriateness in the analyst's internal feeling state. Thus in 1910 Freud seemed to be most interested in a possible problem in the analyst's ability to stay in touch with a patient's unconscious processes that arises from some conflict in the analyst's inner feelings toward the patient (whether or not he was referring only to those induced by the patient's transference), whereas in 1914 he seemed to be warning us about a behavioral danger; that is, the danger of the analyst gratifying transference through either psychological or behavioral action.

Midway between these papers, in 1912 Freud introduced a model for empathic attunement into the countertransference discussion: "[...the analyst must turn] his own unconscious like a receptive organ towards the transmitting unconscious of the patient. He must adjust himself to the patient as a telephone receiver is adjusted to the transmitting microphone. Just as the receiver converts back into sound-waves the electric oscillations in the telephone line which were set up by sound waves, 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...But if the doctor is to be in a position to use his unconscious in this way as an instrument in the analysis...he may not tolerate any resistances in himself which hold back from his consciousness what has been perceived by his unconscious[…]" (pp. 115-1160. It is in relation to this quote (Isakower, too, named his concept from this famous quote), that I have chosen to call the constructive work of the analyst's unconscious *the analytic instrument*.

Whether or not Freud was referring to all of the neurotic components in an analyst, only to the analyst's reactions to the patient's transference, or mainly to enactments based on those reactions, the gist of Freud's concerns seemed to be in direct opposition to some current views that consider countertransference a positive analytic event. Although collapsing the concept of *countertransference* with what I would call the concept of the “analytic instrument” is quite common these days it is important to recall the negative denotations and connotations in the original development and use of the countertransference concept, and to recognize the negative status countertransference had, for years, within the profession. I draw this to your attention now because it will be an important consideration in my argument for separating the concept of countertransference from that of the analytic instrument.

The evolution of countertransference, intuition, and empathy concepts has been complex and highly intertwined and a review of that literature, as interesting as it would be, is not possible here. The one exception I will make, for obvious reasons, will be to review Isakower’s concept of the “analyzing instrument”, a model for the analyst’s “judicious” use of intuition (and association) in interacting with patients. There have been many, quite thoughtful, ways of conceptualizing the analyst's contributions to the clinical setting since 1910 and, setting aside special issues for the moment (such as, illness in the analyst, or the question of self-revelation), it is possible to categorize this literature under three general groupings:

Group 1): Countertransference is indistinguishable from the inner life of the analyst at work, and no special distinction should (or must) be made between the emotional responses of the analyst which *are* predicated on the patient's transference relations to him/her, and those which *are not*. No matter its point of origin, every response of the analyst must, in some way, eventually be related to the patient once the analyst and the patient are in a relationship - this is an intrinsic part of what is involved in being in an analytic interaction with another human being. Thus, there is an artificiality in singling out for special attention only the analyst's reactions to the patient's transference. The analyst's entire personality is involved in his/her relationship to the patient, consciously, preconsciously and unconsciously; countertransference is virtually an ego function of the analyst that has both positive and negative aspects, and it can equally help and hinder the analytic process.

Group 2): The concept of countertransference should be limited to the analyst's reactions to the patient's transference. Countertransference may still be either helpful or harmful, depending on the manner and extent to which both healthy and unhealthy parts of the analyst's personality are brought into

play with the countertransference reaction. Countertransference is still, in this model, not considered identifiably separate from "the analytic instrument" of the analyst, that is, separate from aspects of the analyst's personality that organize empathy, sensitivity, insight, etc. This model, too, maintains the notion that countertransference can be "constructive."

Group 3): Countertransference is a response of the analyst to the patient's transference that *is* destructive to the treatment. It *should* be defined as harmful to the process. This model would differentiate between neurotic reactions that the analyst may independently bring to the analytic situation which can hinder the work in one way, and the neurotic reactions of the analyst that are directly prompted by the patient's transferences that hinder the work in a different way. This model makes a distinction, also, between countertransference as a destructive event which grows out of the chronicity of the analyst's neurosis and the part of the analyst's personality that helps him/her in understanding the psychic experience of the patient. Here there is no possibility of any "constructive" use of being in a countertransference, however this model does suggest that once the analyst has freed himself/herself from actively being in it he/she can use his/her having been in the experience quite productively. In part this is because it is now behind him/her but the main benefit comes as a result of self-analysis, which has moved the material of the countertransference into the analyst's consciousness and into the orbit of his/her ego, and this adds new insights about aspects of the patient's transference and unconscious life that were previously hidden to him/her.

It is very clear even from these highly condensed portraits that our knowledge of how analysis functions, and how the analyst functions within it, has been greatly advanced by contributions of each of the models. However, I would like to pose the following three questions, which I think naturally arise from the differing assumptions: 1) Is there something to be lost by condensing the concept of countertransference with the broad range of internal experiences of the analyst, which, for the rest of this discussion I will call the analytic instrument? 2) Is there something to be lost by not differentiating the analyst's motivations from his/her behavior? And, finally, 3) Is there something to be lost by not distinguishing between inappropriate behavior that gratifies transference and inappropriate behavior that does not?

The Analytic Instrument

The concept of the “analytic instrument” refers to an internal condition of the analyst (which then affects the conduct of the treatment), whereas a concept like the “working (or therapeutic) alliance” (Greenson, 1965; Zetzel, 1956,1966), whether or not one agrees with it (Brenner, 1979) - usually thought to be based on an ego identification with the analyst - refers to how the analyst recruits the patient’s cooperation (a matter of method and technique) in the conduct of an analysis. I think that the analyst's entire personality serves as the basis for the analytic instrument - conscious, unconscious, conflicted and unconflicted - and feel under no obligation, theoretically, to separate out the analyst's "healthy" and "unhealthy" characteristics in positing the suggestion that everything that occurs in the analyst's inner life either is, or has the potential to become, part of the “analytic instrument”. This is not the equivalent of suggesting that conflict that detrimentally affects the treatment is also part of the analytic instrument. We can readily differentiate between using even one's conflicts as a method of trial identification with a patient, and having certain other conflicts that work against empathic relatedness. The former is part of the analytic instrument, and the latter is either countertransference (if it gratifies transference) or bad therapy (if it does not). I will emphasize, and say more about, this distinction shortly. Everything in the analyst’s personality is put to use by the analytic instrument, however the analytic instrument is not the same as the analyst’s personality.

Although I am suggesting that the analyst's entire personality can be brought to bear on every patient's difficulties, I am unwilling to grant this same status to countertransference. To equate everything that the analyst experiences with countertransference and, especially, to describe a pre-existing neurotic

conflict as countertransference seems both descriptively and dynamically incorrect; particularly in the latter case, where the neurosis and, as a result, the potential for transferentially influenced object relationships, has preceded the patient. Defining the analyst's neurotic conflicts as part of the countertransference becomes a superego, rather than an ego, posture whether or not we consciously intend it to, and this works against our best interests in self-analysis; and, in clinical analysis it works against the best interests of the patient. It is the very opposite side of this coin to suggest that the analytic instrument is benefited not only by the unconflicted parts of the analyst's psyche, and to emphasize that it arises from the conflicted parts, as well. The use of current conflict in the service of the analytic instrument needs to remain understood as an ego, not as a superego, function but the danger here of slippage is considerable, precisely because the conflict is still current.

While there may be a temptation to view the analytic instrument as a form of participating-observation or as a form of projective identification it would be incorrect, in my opinion, to do so. Projective identification, for example, is a defensive operation that may play a role in the analytic instrument, but it is not the equivalent of it. It is a way that the analyst may be affected by the patient, just as introjective identification is a way that the analyst may be affected by the patient, nothing more. As such, it may be blended with direct identifications, complimentary identifications, concordant identifications, dis-identifications, counter-identifications, projective counter-identifications, ego identifications and superego identifications in the mind of the working analyst; all of which are, then, balanced against each other, worked-over, and filtered through the analytic instrument in the service of the treatment. Although all of these exercises in identification will affect the internal picture that the analyst forms of the patient many other processes, quite different from identification processes, also affect that picture; for example, transference distortions, “objective reality”, the nature of the analyst’s own conflicts, the analyst’s preferred pathways of defense, the analyst’s blind spots, and the relative ease or difficulty of the analyst’s access to his/her unconscious, to name just a few.

To examine the difference between the analytic instrument and participant-observation requires a somewhat fuller overview. The interpersonal approach known for years as participant-observation got a considerable boost with the emergence of relational theory, intersubjectivity, and self psychology. Participant-observation is more commonly referred to today as “observing-participation” and, in addition to describing an analytic technique, it is also a way of understanding the therapeutic action of psychoanalysis. Observing-participation is an interactive posture of the analyst; it uses patient-analyst interaction to explain both how and why the contents of the analysis, a specific hour, and the therapeutic relationship itself, are motivated and shaped. Although observing-participation frames the analyst’s state of mind, it goes well beyond being only an internal psychological event. Whether the focus is on the enmeshment of the analyst in the patient’s world or, at some other point in the treatment, it is on the patient’s separate sense of self, primary emphasis is always on the ways the patient and the analyst affect each other. Unlike the way I (or Isakower, who I will come to next) would conceptualize the analyst’s participation, the redefinition of “participation” in “observing-participation” refers to the analyst’s unwitting living out of core intrapsychic themes with the patient. As a consequence of redefining “participation” transference is also redefined, with a major shift in emphasis; it is not seen only as a fantasy production of the patient (involving displaced thoughts, feelings, wishes, fears, etc.) and it is understood, instead, as also being a form of perception (Greenberg, 1991). Hirsch (1996), in describing the far-reaching implications of that shift, points out that in addition to the shift from “only fantasy” to “also perception”, who possesses the transference also shifts; abandoning the original concept of transference as belonging only to the patient, observing-participants now view transference as being part of a jointly constructed interactional (transference-countertransference) matrix. This then also places special emphasis on the mutative nature of the analytic interaction rather than solely on interpretation; what *is* interpreted by observing-participants is - the mutual enactment of internalized relational experiences (Mitchell, 1988) as they emerge and are observed in the unwitting participation of both parties in the lived-out transference-countertransference, interaction, matrix.

Let us now compare Isakower's concept of the "*analyzing* instrument" (a concept that has considerably more in common with mine than does projective identification or observing-participation) with my concept, the "*analytic* instrument".

Otto Isakower described his concept "the analyzing instrument" in a pair of (unpublished) lectures on supervision delivered to the faculty of the New York Psychoanalytic Institute (1963a, 1963b). Both our concepts have things in common, that is only to be expected, but they are different in some important ways. Although his thinking touched on some structural considerations and on some variations in narcissistic regulatory processes, Isakower was opposed to describing the mechanism of the analyzing instrument as occurring through the process of identification (which is of key importance to me). He thought the issue was one of boundary permeability; i.e., two altered states of consciousness, complimentary modes of awareness, set in relation to each other (in this respect, Isakower's ideas have more in common with the concept of observing-participation than they do with my concept of the "analytic instrument").

Isakower's analyzing instrument is a merged state of mind. It is not a state of mind of the analyst alone (as is my concept), and it is not a state of mind of the patient alone (which is not part of my concept); it is, rather, a shared state of mind, an active interpenetrating state of mind in which both analyst and patient equally participate. In other words, Isakower's concept is not a commentary on how the analyst's mind is employed as an independent structure, it is a commentary on a conjoint entity - an entity shared by patient and analyst in roughly equal parts, a merged state of mind achieved through mutual regression in the analytic process..

This shared entity may be mutual and equal in influence, and it may be mutual in each party's reliance on analytic regression, but the regression experienced by each is achieved through different processes. The mechanism of regression for the patient is a by-product of free associative functioning. Free association is a kind of controlled regression in which certain critical faculties are suspended, thus permitting into consciousness the emergence of chaotic, irrational, non-linear, imagistic material. Further suspension of critical faculties then permits those thoughts, feelings and images to be spoken out loud in the presence of the analyst. The complimentary act of controlled regression for the analyst is achieved in the trance-like, almost sleep-like state of evenly hovering (Isakower preferred the term *hovering* to "floating" or "suspended") attention. These two states of mind are blended into a single entity, the analyzing instrument; they are two halves of a single unit that dwells somewhere between the analyst and the patient, bypassing the usual boundaries we commonly think of as existing between people.

One of the most important features of Isakower's concept is its topographical nature. The analyzing instrument makes use of an altered state of consciousness, a state that is (for both parties, not just the analyst) closely related to trance and sleep-like states, and to hypnotic states. In that altered state of consciousness the usual defensive barriers between the layers of the mind are relatively relaxed. In a state of relaxed guardianship it becomes possible for unconscious and preconscious contents to become accessible to consciousness in ways that are not ordinarily possible.

Three converging processes are brought to bear on the analyst's functioning when in this regressed "merged" state, processes that can generate both a high degree of empathic relatedness and an enhanced method of intervention by the analyst. First; when the analyst is in a regressed condition it is more likely that responses to the patient's productions will be less verbally focused and, therefore, less distanced from the material. That is, the likelihood of the analyst encountering affective, auditory, visual and sensational (including bodily) cues during the hour may allow the analyst to become uniquely connected to the patient's elemental experiences with a high degree of immediacy. Second; if the analyst is closer to his/her own primary process functioning during a state of relative regression, it is likely that he/she will be able to recognize the primary process connections in the patient's regressed (but also defended) productions. And, third (and perhaps of most importance to Isakower); in a state of regression there is an increased opportunity for images to arise in the analyst in response to the material

produced by the patient. These images, representations, pictures, sense experiences, etc., originate in the analyst but they are directly stimulated by the patient's material, and Isakower thought that they will - despite being involuntary productions (associations) of the analyst - properly match, or compliment, the salient features of the patient's inner life.

These processes foster a kind of psychological "nearness" between the patient and the analyst. Not an equivalence between their character structures but a complimentarity in how they function when together. Isakower thought that in this state of psychic nearness the analyst would be able to preconsciously select interventions that are likely to resonate unconsciously and preconsciously in the patient. They resonate in the patient in a non-threatening way and that is what, then, facilitates topographically upward movement of the patient's material. This is because, although the intervention may be anxiety-provoking on one level it is also, at the same time, consonant with both the unconscious wishes and the unconscious defensive needs of the patient. This is one of the ways that Isakower's concept and mine really differ. Isakower's concept is much more action oriented. In the dream-like state of enhanced intuition Isakower's analyst "judiciously" associates to the patient's material. This brings up in the patient more and deeper layers of the unconscious. My concept, while also contributing to how modes of intervention are ultimately framed, is less directly tied to a particular form of technique. It is concerned, mainly, with how the analyst builds an inner representation of the patient, how the patient's psychic world is represented inside the analyst's head, and the nature of the resources the analyst uses to achieve empathy and an understanding of what is going on in the treatment.

One is reminded of Fliess' (1942, 1953) explanation of what makes some interpretations mutative, and others, not. This is not surprising because, during his presentations, Isakower quoted Fliess extensively. In Fliess' view, the analyst, at the very moment that he/she becomes the direct instinctual target of the patient, generates unconscious motives for action, that is, specific interventions (interpretations) that are partly informed by his/her unconscious reactions to the patient (not general transference reactions, or "reality" reactions, but unconscious reactions that are stimulated by the special pressure of being targeted in that way). These interventions, the analyst's interpretations during those moments, have the potential to impact on the patient at multiple levels of psychic functioning simultaneously and this is because they are informed, in large part, by the analyst's preconscious and unconscious. Interpretations which are formed in that context - interpretations that can act on multiple levels - have the potential to be mutative, Fliess argued, whereas interpretations that arise more "intellectually" do not. Although I think my concept goes further in describing the inner experience of doing analysis, and although I might feel somewhat hesitant to *associate* with patients as freely as in the example to follow, I am in basic agreement with both Isakower and Fliess in their ideas about how (when things are working well) the unconscious constructively informs the choices, the interventions, and the interpretations of the analyst.

Balter et al. (1980) have recast Isakower's analyzing instrument along modern structural lines, bringing it into a somewhat more contemporary frame. For instance, they would not exclude identification as part of the analyzing instrument, and see it as a parallel event within it. They provide an excellent (as well as a brief) example of how Isakower's analyzing instrument works in clinical practice, and present their understanding of it. This is an example that one can trust (i.e., the analyst really behaved they way they said he did) because, as they say, they discussed it in detail (as an exemplar of the analyzing instrument) with Isakower himself. This is a good example for our purposes, too, because it shows how the implementation of Isakower's concept leads to very different kinds of clinical action, and a different clinical conceptualization, than would be found with my concept, the analytic instrument.

This is how Balter and his colleagues describe and explain it:

"During a particular phase in her analysis a young woman was becoming aware of strong phallic conflicts and a feeling of being genitally deficient. One day she told the following dream. She had only

one breast. She was to go to the hospital the next day 'to have a breast removed.' In telling the dream, she was not sure if the operation was depicted as already having occurred or if the remaining breast was to be removed. The concern about breasts had started the previous week when she was looking through a magazine with nude photographs of a famous movie star, now in her forties. The patient had been impressed with how the actress's breasts were so well preserved. The day before the dream she had the thought that the actress's breasts had been treated with silicone injections. She recalled that someone had told her that women who have such operations have 'strong masculine strivings.' She then talked about her adolescent 'tom-boy' phase when, although she felt quite feminine, she played with boys, excelled in their athletics, and depreciated other girls as 'silly.' She felt her boyfriend compared her favorably with other women because of her intellectual proficiency, which she considered a masculine quality. She wished the analyst would do the same. The analyst remarked: 'You seem to feel I want you to be a girl who is also a boy. The ambiguity about the operation in the dream indicates this.' The patient remarked that she felt her father wanted her to have been a boy.

As the idea of the mythical Amazons of ancient Greece kept coming to his mind, the analyst asked her if she knew about them. She answered: 'Yes,' but could say no more about them. He went on to tell her that they were women who cut off one breast in order to be able to use bow and arrows, as men did. In response to this the patient remembered having recently complained to her mother that she (the patient) could not throw a ball well. To which her mother replied, somewhat humorously, that the patient's father said it was because 'the breasts get in the way.' The patient then had a visual image of Diana the Huntress, carrying bow and arrows and wearing a garment leaving one breast exposed. For the rest of the hour and during several succeeding sessions rich material from dreams and memories came to the fore, indicating a childhood fascination with the myth of Diana and Actaeon, a story which had served to structure the patient's infantile conflicts and defenses" (pp. 492-493).

They continue: "Here, as in ordinary discourse, a communicative interchange took place between the two people, leading to an increase of understanding. However, unlike ordinary discourse, this communicative transaction occurred on a regressed level of mental functioning. The content of the analysand's dream and associations evoked in the analyst an apparently idiosyncratic idea: the Amazons. We would suggest this represents a condensation of two ideas: mastectomy and masculine strivings. The dominance of the primary process in the analyst's subsystem in the ego is here manifest. The analyst not only attended to his own spontaneous and involuntary ideas, he also suspended the critical judgment which might have led him to dismiss the idea as an irrelevant intrusion. The analyst's communication evoked further material from the patient. This example indicates how the two regressed subsystems functioning together led to the further elucidation of the patient's fantasy-memory constellations" (p. 493).

Although it is very tempting, I will not discuss (in terms of how one uses Isakower's concept) the criteria the analyst might utilize in deciding what, and how much, to convey to the patient about his/her involuntary reactions, ideas and feelings (that is, the - as they put it - "judicious" use of the analyst's associations); I do not take this up at this time because it would simply lead us too far astray and, in any event, Balter and colleagues cover that ground quite nicely themselves.

To see, as a contrast, how my concept would be clinically employed let us consider the therapeutic problem of a cross-gender analytic dyad; the typical one, the pairing of a male analyst and a female patient.. In some ways you will see similarities but the difference, especially in how the therapeutic work is conceptualized for the analyst, will be apparent.

It is not unreasonable to suggest that a male analyst who is working with a female patient who has prominent conflicts about penetration may be impeded in his understanding of her by reaction-formations against homosexual wishes (when she talks about penetration) and, also, by neurotic opposition to the feminine and bisexual identifications that quite naturally will arise (opposition generated in response to the castration/penetration anxieties and fantasies stimulated in him by his patient). However, it is by no means paradoxical to suggest that his appreciation of her situation will also be served by these very same

conflicts. We can enumerate certain areas of unresolved conflict that this male analyst can, and must, access in order to empathize with, and have an intuitive understanding of, his female patient and her concerns about penetration. Most obvious are his own fantasies about both the pleasures and anxieties of penetration; fantasies based on negative, passive oedipal strivings in his own childhood; fantasies which have been very much retained in his unconscious. He will also have unconsciously preserved other, even more infantile, beliefs about the possibility of incorporatively internalizing objects (and their parts) whether by mouth or anus, which are obviously penetration prototypes. He uses a wide range of conscious, preconscious, and unconscious fears of body damage related to both penetration and castration. He may draw upon the revival and re-animation of many earlier, or present, conflicts he may have about passivity and activity. And, he will inevitably tap into his own superego conflicts about sexuality and aggression where penetrating, and being penetrated, is concerned. I will stop here although it is apparent that there are many other conflicts that have been left undescribed that could be put to advantageous use by this male analyst. For a more detailed examination of how male analysts use their unconscious primary process resources when working with women patients see Lasky (1989).

Tapping into all these personal conflicts is necessary for him to have any intuitive appreciation of his female patient's penetration conflicts and, in fact, it is not just necessary but essential; it is only by actively using these conflicts, and not by any force of mere intellect alone, that he will be able to do so. Self-reflection and awareness of his own psychological condition; that is, a continuing self-analysis at the very same time that these conflicts related to his work are mobilized in him, permits him to decrease the power of anti-cathexis, of counter-identification, and of reaction-formation; and it is through the interplay of self-analytic work and these active conflicts that he continues to increase his conscious and preconscious awareness of his patient's internal experiences and conflicts.

This is, I believe, an example of what Freud was referring to when he suggested that all analyses proceed only as far as the analyst's self-analytic skills permit. And, the active use of the mind in this way is the “analytic instrument”.

Separating the concept of countertransference from the concept of the “analytic instrument”, along the lines of differentiating what the analyst does from the state of his/her inner life, also seems to have some value if it leads to more effective insight in the working analyst and more effective insight into the patient. I am now drawing a line between the internal life of the analyst and his/her behavior with patients. This brings us then, once again, to our earlier question: assuming that we are only referring to things the analyst does that detrimentally affects the treatment, is there a meaningful difference when what he does wrong is transferentially gratifying and when it is not?

Countertransference *versus* “Bad” Therapy

Let us approach the question by positing a hypothetical analytic situation in which we compare the effects of a consistent neurotic behavior of the analyst on two different patients; in one case it will "interface" with the patient's transference, and in the other, it will not. First, let us have a portrait of each patient, and then a description of the analyst's neurotic problem:

Ms. X comes to analysis to solve long-standing difficulties in her love relationships. She has had a history of becoming romantically involved with older, married, or otherwise unavailable, men. We learn, as the analysis progresses, that she had for many years (in fact, until the onset of adolescence) a grossly overstimulating oedipal relationship with her father, which we understand to be being repeated in her current sexual and romantic object choices.

Ms. Y comes to analysis to solve an acute, seemingly reactive, depression. She had not progressed as well as she should have in a one-year master's degree program and instead of being given a chance to repeat it, she was asked to leave the program. She became deeply depressed for the next three years and then entered analysis. We learn in the analysis that Ms. Y's mother suffered a psychotic *post partum* depression and could not tolerate much contact with Ms. Y for the first year after her birth. Ms. Y came

to experience her mother as if she were a dead object, and turned away from her reactively as well as defensively. We may assume now that her behavior in that one-year master's degree program involved a re-enactment of this, and can assume that Ms. Y's seemingly reactive (but unconsciously chronic) depression, which consciously started when she was asked to leave school, actually had its origins in the earlier rejection of her by her mother. I will only mention the obvious about her depression being an identification with her mother - a restitutive attempt to overcome early object loss.

Now we can introduce Dr. Z who, like Ms. X, had an oedipally overstimulating childhood. In his case, however, the incestuous attachment was passive and negative. Dr. Z's neurotic resolution was the development of a "Don Juanish" kind of reaction formation against those passive negative oedipal wishes that he now directs toward all women indiscriminately. For the sake of this example, let us assume that whatever else he may be constructively capable of, at one point or another this difficulty, no mere surface deficiency, makes its appearance in both Ms. X's and Ms. Y's analyses.

In Ms. X's analysis, when his inevitable seductiveness becomes introduced into the treatment, Dr. Z is directly gratifying a transference wish, as well as playing into certain transference- and reality-based fears. Ms. X will, of course, be extremely ambivalent about Dr. Z's behavior; on the one hand, she will find it objectionable but, on the other hand, she may well find it irresistible. Will Ms. X find it more objectionable than irresistible (since it repeats a trauma), or will it work the other way around? If this behavior takes place in the analysis before her oedipal attachments have been renounced we may safely predict that Ms. X will lean toward being drawn in by Dr. Z's seductiveness rather than rejecting it; especially if Dr. Z's seductiveness is subtle and symbolic and, therefore, processed only preconsciously and unconsciously by her. If they join neurotic forces in this way, Ms. X and Dr. Z have begun to symbolically replay one of the most destructive events of her childhood; a chronic, incestuously-driven relationship that has prevented her throughout adulthood from finding happiness with any man who is not a pathological substitute for her father.

What happens, then, as they continue to meet? Because her pathological transference needs are being gratified by Dr. Z's behavior the transference neurosis becomes severely compromised. Dr. Z's erotization of the relationship generates a disorganizing reality trauma for Ms. X and it is likely that she will have progressively less ego available to recognize the inappropriateness of Dr. Z's conduct the longer it persists. One expects that certain superego functions will also be detrimentally affected the longer this goes on. Although Ms. X came to analysis to work out her craving for an incestuous object she is now locked, once again, into her neurosis, this time by her analyst. Ms. X is not merely in the situation she was in before - her situation has become considerably worse. Ms. X's transference neurosis has been transformed into a mutually enacted transference psychosis; the two clinical neuroses have become interlocking and, most unfortunately, further analysis will not be possible for Ms. X until something else upsets the neurotic balance they have established.

In the second analysis, Ms. Y's analysis, Dr. Z's seductive behavior has much less power to be quite so disruptive because his conduct is not so interlocked with Ms. Y's wishes. It does, on one level, satisfy a particular aspect of her transference: a hope that she might be able to have in the analysis the opposite of the mother she actually did have during her first year; that is, her wish, in the transference, for an involved mother (in the analyst) who would have adequate libidinal supplies consistently available for her. However, Dr. Z's sexualized interest in Ms. Y is not the same thing as providing appropriate libidinal supplies and, surely, however much Ms. Y might view it as maternal interest in the transference, one would not suggest that Dr. Z's erotized behavior would be metabolized by her as the "good mother" opposite of the kind of "bad" mothering that characterized Ms. Y's infancy. Dr. Z's sexualized stake in her may well gratify some small neurotic aspect of Ms. Y's transferential wish for a deeply involved mother, but this bears little relation to her neurotic and non-neurotic wishes for the kind of deep involvement on the part of her analyst that would represent the adequate holding environment that her mother did not provide. Because Dr. Z's behavior does not trade on the central core of Ms. Y's wishes and is, therefore, less disorganizing it may be possible that more ego remains available to her than was left available for

Ms. X. If this is true, she is much more free than was Ms. X to continue to maintain her strivings in the analysis for relevant transferential gratifications (leading, despite Dr. Z's neurotic intrusions, to a continued deepening of the transference neurosis).

One might wonder at this juncture whether neurotically motivated encroachments in the analyst's relationship to the patient can ever co-exist with a continuing analytic process. Common experience suggests that neurotic conflict in the analyst inevitably enters every treatment without every treatment suffering disastrous effects. This appears to be the natural condition of every analysis (since we may not all be clinically neurotic, but no one is without neurotic conflict). Perhaps the reason why we can still work as analysts even though we all have neurotic conflicts is because neurotic conflict need not, inevitably, have a destructive effect on the treatment if it does not directly inflict damage to the transference neurosis. It may impede an analysis in a variety of different ways, but it certainly does not make it impossible. If it did - given the imperfection of analysts - no one would ever be analyzed.

We must ask now, as we did with Ms. X's analysis, what happens as Dr. Z and Ms. Y continue to meet? On Dr. Z's side neurotic wishes are less satisfied too because Ms. Y, unresponsive to his need for sexual reassurance (unlike Ms. X), will have frustrated him in this. This might lead to two possible outcomes: either Dr. Z may intensify his efforts to seduce Ms. Y, or he may reduce them. We assume that Dr. Z's neurotic conflicts would become even more pressing and even less resolvable if he had achieved a meshed neurotic relationship with Ms. Y, like the one he had achieved with Ms. X, because acting out of that sort would further impair *his* ego and superego functioning. But suppose Ms. Y calls this to Dr. Z's attention (as patients often do when the analyst is having a problem), and suppose that Dr. Z is not so disturbed that his only option is to escalate; Dr. Z may then be able to use Ms. Y's complaint as a signal to himself that his own conflicts are threatening the analysis and that serious self-analytic work has become necessary. Unless he were very profoundly disturbed, perhaps more than neurotically disturbed, Ms. Y's rejection of his behavior would act as a prod to resolution rather than perseverance. Whether or not Dr. Z can work this out, Ms. Y is in a better position to cope with his behavior than was Ms. X. Unlike the situation with Ms. X, whose ego autonomy was interfered with as her conflictual involvement with Dr. Z progressively deepened, Ms. Y will not have had so much of her of ego resources bound up by Dr. Z's attempts at seduction, nor will she suffer the same fate in her superego functioning. Therefore, if Dr. Z intensifies his seductive behavior, it is quite likely that Ms. Y will be able to more consciously (and, hence, more realistically) perceive that something is amiss in Dr. Z's behavior and she is in a better position to continue to call it to his attention. If that does not work then she will certainly have more freedom to terminate this treatment than would Ms. X (perhaps not easily since, presumably, this would not have been the only thing the analysis was about: but, in the worst case scenario, at least it is more in the realm of possibility for Ms. Y than for Ms. X).

Now let us stand Ms. Y's transference on its head and look at this from the other way around: One might raise the objection that Dr. Z is, in fact, gratifying a rather different transference wish of Ms. Y's in his seductive behavior; that is, that he is as bad an analyst, under these analogous circumstances, as her mother was during Ms. Y's first year. It is certainly possible, given her history, that Ms. Y may have had some masochistic needs or perhaps a need to make her passive experience of bad mothering active. If so, they might achieve some secondary gains as she endures a symbolic repetition of the experience of her first year with her mother in the analysis. We should make an important distinction here; simply being like a significant past object (particularly when one is being like that past object at its worst) is not the same as gratifying a transference wish.

However if this behavior may not have satisfied a transference <u>wish</u> it most certainly did satisfy an <u>expectation</u> and a <u>fear</u> in the transference. An expectation that she might find the worst aspects of her mother would, if anything, probably make Ms. Y especially vigilant and on guard against any hint of schizoid or depressed functioning in Dr. Z, but we would not anticipate that Ms. Y would be as equally wary and cautious (in a neurotic way) about intrusive sexuality in him. Therefore, Dr. Z might have the room to intensify his seductiveness. She would probably be able to identify his seductive behavior as

inappropriate as Dr. Z's frustration pushes him to greater excesses, but with a very different consequence, because it lacks corresponding significance in the major features of her transference wishes. Wishes, fears and expectations often find highly transformed modes of expression, but they are also highly specific in their latent meanings. Hence, not only would Ms. Y have ego and superego resources available to resist such behavior, she might be even less tolerant of Dr. Z's seductiveness precisely because it did not latently capture the way her mother really was inadequate.

We can see from the comparison of these two hypothetical cases that it does not seem particularly useful to categorize all neurotic conflict of the analyst that makes its appearance in a treatment in the same class with those situations in which the analyst's neurotic conflicts actively have a destructive effect on the management of the transference neurosis. These “cases” demonstrate yet an additional disadvantage of lumping together all the situations where the analyst's neurotic conflict harms the treatment, this time having to do with ego and superego functioning rather than with the transference neurosis, since in some of those cases patients will not have their resources as greatly impaired by the analyst, and in other cases patients will suffer serious impairment of their resources. Patients like Ms. Y (whose transferences are not being gratified) may have the freedom to do something constructive about the damaged analytic situation, and patients like Ms. X (who are locked into the situation because of their gratified transference) may not.

My discussion thus far has focused on differentiating the inner state of the analyst, that is, the analytic instrument, from his/her behaviors; and, on differentiating between either temporary or permanent behaviors that only hamper an analysis because they permit the transference neurosis to remain intact, and a second class of temporary or permanent behaviors (for which I reserve the term: countertransference) that have the potential to destroy an analysis through corruption of the transference neurosis. Before I attempt to present a model for how I think the analyst puts his instrument to work, it may be instructive to have two clinical vignettes that I think exemplify the differences, as I see them, between the analytic instrument and countertransference (including how one can use countertransference to the patient's advantage after one gets out of it; assuming one *can* get out of it).

An Example of Countertransference

A female patient with an explicit erotic transference, filled sessions with graphic descriptions of her sexual fantasies and conduct. As the transference deepened, the patient's fantasies became focused on the analyst. When this happened, he found himself uncomfortably stimulated, and he began to feel extremely guilty. He was excited, he wished it would stop, and he wished it would continue: all at once. Being unable to stop having erotic reactions and further eroticized wishes in response to this patient's frank sexual fantasies about him, he began to become furious with himself; and, he was beginning to feel quite angry with the patient, too, for making him aroused during sessions (which she had openly admitted to wanting to do).

He was aware of the inappropriateness of his reactions but, nevertheless, was unable to listen to his patient as dispassionately as he wanted to (and as impartially as he felt he needed to be able to), in order to be of any help to her. He determined, quite consciously, that he would not act out either his sexual feelings with this patient or his angry feelings. He also believed that he should not act aggressively toward himself in this situation. He recognized, intellectually, that there was some sort of therapeutic impasse expressed by his sexual response, and he thought that by being actively aware that a problem existed he was, at least, on the way to resolving it. His idea was that as long as he felt out of control, and he did feel badly out of control, it would be best for him to take no actions in the treatment. He recognized that this was exactly the kind of situation in which analysts sometimes take inappropriate action, because they feel too uncomfortable to permit the situation to remain in that condition. His rationale for choosing not to take any therapeutic action, i.e., no interpretations, no limit setting, no questions, no clarifications, no reconstructions, etc., until he felt more in control, was his concern that any

action he might take would not be an informed action; that is, it would not be based on a neutral decision about what was therapeutically best for the patient.

On the other hand, he was quite suspicious of the idea that he should do nothing, and change nothing, in the treatment until he felt in more control of his responses. This was because he did not entirely trust his own motives: he believed, intellectually, that he had arrived at this as a rational decision, however, since without successful analytic intervention he had no expectation that the situation would spontaneously change, he was worried that he was lying to himself, and that he had arrived at that decision only in order to satisfy a neurotic wish to obtain more sexual satisfaction from the situation. His fear was that this was not really rational but just a rationalization, so that she would be able to keep talking dirty to him, and so that he could keep responding with excitement. These fears notwithstanding, he still felt that it made most sense to take no action until he felt he had a better handle on the situation. And so for several weeks the patient recounted her sexual fantasies about him, with intentional provocativeness, uninterrupted and uninterpreted, while he hoped that, through simultaneous self-analysis, his conflicts would become resolved enough for him to become active once again in the analysis. He felt that this was possible because he had some confidence in the process of self-analysis, and also because he thought that he knew something about the transference paradigm this patient was enacting. Another, less charitable way of describing this would be to say that, despite what he thought he knew, the analysis was stalemated for a number of weeks.

The patient had a grossly overstimulating, sexualized relationship with her father until she reached adolescence. Beginning with her earliest memories right until the present, she could recall having sexual fantasies, with explicit content, about her father. The contents of those sexual fantasies matched the contents of her sexual fantasies about her analyst, and it was apparent that this erotic transference was paternal in nature. She had, from the viewpoint of an oedipal child, an ideal relationship with her father until adolescence; he spent a great deal of time with her, and they regularly played together in ways that were always eroticized and very exciting, even if not explicitly sexual. She identified her entry into puberty as the factor that disrupted her libidinized relationship with her father, and recalled longing, desperately, for time to be reversed, throughout adolescence. Sexuality became permitted between them only if it took aggressive forms. The nature of their interactions were barely concealed sexual encounters, but concealed enough, through aggression, to make them possible. For example; she and her father would have ferocious fights which would end up with her closeting herself in their finished basement. The fight would continue through closed doors, and the most customary form in which their battles ended was with her father shouting, "Fuck you, goddammit," down the stairs, and with the patient screaming back, with equal volume and feeling, "Goddammit, you wish you could!"

The analyst thought that the transference was quite clear, including both the sexuality and the aggressiveness of her relationship with her father: the patient was shouting "You wish you could," with every explicit sexual fantasy she leveled at the analyst, and the analyst was supposed to be responding with frustrated, angry sexuality, just as her father did at the top of the basement stairs. With this knowledge of the transference, the analyst retreated into therapeutic inaction, hoping for continued self-examination to bring about some resolution of his sexual excitement and anger. The neurotic contribution of the analyst, which he conveniently forgot, was his tendency to withdraw from contact when stressed. Things continued this way for some time until one session when the patient added something new to her fantasy; she was describing how much the analyst would enjoy what she was doing to him in the fantasy when she remarked that she would like to be able to see his excitement better. His face was not sufficiently visible to her so, in that fantasy, she chose to imagine him without his beard and mustache. The session came to a close with nothing any closer to resolution.

For the rest of that day, the analyst had an aria from Saint-Saëns' opera, *Samson et Delila*, running through his head. This is an analyst who frequently had music running through his head, and so, at first, nothing about this seemed remarkable to him. However, at some point, he became aware that this was not typical of the kind of music he usually imagined, and this led him to wonder why *that* opera, on *that* day.

As he began to think about the story told in the opera, of Delila emasculating Samson by cutting off his hair, he had a sudden flash of memory; of the patient saying that she would like to have him clean-shaven in her fantasy. He then had the thought, with great amusement (that clearly betrayed as much anxiety as it did insight), "And what happens if you cut off an analyst's beard?"

With that thought, the analyst recognized that underlying the patient's erotic transference was another destructive transference, in which she emasculated her father as a punishment for sexually abandoning her.

Just as in the story of their fights, where her father was made impotent ("You wish you could!), the analyst had been made therapeutically impotent by his discomfort with his sexual responsiveness and his anger. He was unable to analyze, emasculated as a professional, truly "an analyst without a beard." In response to this insight his reactive responses subsided, and he was able once again to behave like an analyst instead of her fantasied father. Rather than continuing to shy away from her fantasies, the analyst explored them more deeply, eventually enabling the patient to explore and recognize the angry, destructive, punishing rage underneath her seductiveness and the appearance of sexuality in her fantasies about the analyst.

The Contribution of a Neurotic Conflict to the Effectiveness of the Analytic Instrument

Mr. A's early childhood was marred by exactly the same circumstances of the hypothetical case of Ms. Y, whose psychotically depressed mother could have no contact with her for the first year of life. Much of Mr. A's treatment had been taken up with his growing understanding of his mother's behavior as a pathological condition, rather than as a personal rejection of him. He had spent much of his childhood trying to figure out what he could conceivably have done that was so wrong that it would have made his mother turn away from him; and, much of his early relation to the analyst was a careful, guarded, approach designed to make sure that he did not displease the analyst in any way. He seemed a very nice man, with essentially a forgiving nature, until the analyst's view of him was changed by a fantasy he (the analyst) had.

Mr. A's treatment hour was at 9:15 PM, on a cold wintry night. The streets were deserted, and the analyst was alone in the suite of offices he shared with professional colleagues. By coincidence the two hours before Mr. A's session were canceled that evening and the analyst, having been more tired that day than usual, took advantage of the break and dozed off in his chair (having set the alarm to awaken him at 8:45pm). At about 8:30pm the analyst was startled out of sleep by something - perhaps a noise, perhaps a dream - he could not be sure.

With a feeling of considerable unease, the analyst checked the other offices: the suite had been burglarized about two months previously, and the analyst feared one of those horrible situations were the burglar finds someone home and shoots him when he is discovered. The offices were empty, and the analyst had no way of knowing what startled him. Growing out of his own castration anxieties, which either stemmed from something that the analyst had dreamt but forgot, or from his fantasy of being shot by a burglar, the analyst began to fantasize about being able to catch the burglar unawares, disarming him, and shooting the burglar himself. In the midst of these narcissistically grandiose and restitutive fantasies, the analyst began to have a concern about Mr. A, who was due to appear for his session in about 10 minutes.

The analyst imagined Mr. A kicking open his office door, and shooting him in the chest with both barrels of a sawed-off shotgun, replete with vivid images of his shredded insides and an exit wound about the size of a basketball. This fantasy caused the analyst to have the same sweaty palms, palpitations, and shortness of breath that he experienced earlier when he imagined that a burglar might actually be hidden in the office suite somewhere. He said to himself that this was a ridiculous fantasy, totally unbelievable; Mr. A was not the kind of a person who would do something like that! Nevertheless, none of his anxiety symptoms were relieved by these thoughts. He then recalled a story he had heard, earlier that week, about

an analyst whose former patient came to the office with a gun and forced the analyst to take him to his bank and withdraw all his money, which the patient then took. He thought to himself that it was fortunate that other analyst was not hurt in the incident, and then he had the disturbing thought that the other analyst probably did not expect his patient to behave that way either. This did not make him feel reassured, and his anxiety symptoms began to escalate almost to the point of an attack of panic.

Seeming as if it were just a figure of speech, the analyst said to himself, "Good grief, what did I ever do to deserve this?" Remarkably, the anxiety began to melt away, and the analyst was left with that thought: "what did I do to deserve this?" Almost instantly, the analyst realized that this really did have something to do with the relationship between Mr. A and himself. Underneath Mr. A's friendly and coöperative facade, the "good boy" presentation designed to never make the analyst angry enough at him to abandon him, the way his mother did, was a towering rage. The transference had changed without the analyst having consciously become aware of it. The patient, having made considerable gains in analyzing his neurotic guilt, and considerable progress in realistically examining his mother's possible motives, was now free to contain his fury at having had the kind of childhood he did with her. This wish to punish his mother, warded-off and denied all of his life, was liberated by the work of the analysis and had very subtly entered the transference. The analyst apparently had some unconscious and emotional recognition of this, which is what permitted his castration anxieties to express themselves in the fantasy about Mr. A with the shotgun. The fantasy represented, quite graphically, the work of the analyst's comprehension changing from an unconscious awareness to a preconscious awareness. With fully conscious recognition of the meaning of the fantasy, the analyst's cognitive awareness of the subtle changes in the transference became possible; he now knew intellectually as well as viscerally what he did (as the mother in the transference) to deserve that punishment, and the analyst no longer needed to fear Mr. A's arrival. Mr. A's analysis continued to progress nicely as this aspect of his inner life became subject to the analytic work.

At no time, did the analyst enact anything related to the neurotic part of the fantasy with the patient. This fantasy, a blend of the analyst's neurotic castration anxieties and his unconscious recognition of a change in the transference; the subsequent preconscious reorganization of it into the analyst's question; and, the conscious insight it led the analyst to, about the change in Mr. A's transference relationship to him: all exemplify a concept of the analytic instrument that is quite different from what I think of as countertransference.

Given this example, how, then, might we think about the dynamic interactions between countertransference and the analytic instrument? What I am about to present is not a clinical theory, it is a metaphor; a metaphor that I hope will stimulate further thinking that may eventually lead some of us to a more fully worked-out model of how the analyst uses his inner life.

The Dynamic Nature of the Relationship Between Countertransference And The Analytic Instrument

Imagine, if you will, that people's personalities are like a harp (As long as we have metaphorized the analyst's capacities to function analytically as an "instrument," we might as well stay with it.), a harp with dozens of strings, some of which stand for conflicts and some of which do not; a harp where one string can be plucked independently, where many strings can be sounded at the same time, and where the sounding of any single string will cause certain other "unplucked" strings to sympathetically resonate in a series of harmonic overtones on that harp, and, also, on any adjacent harps that might pick up the vibrations that are in the air. Let us also assume that all strings, across all the octaves, that sound the pitch of "C" stand for conflicts; different "C's" standing each for their own particular kind of conflict.

If it happens that the "middle C" of the analyst's harp rings out, indiscriminately, with every single patient who walks through his door, we can assume that the analyst has a chronic neurotic conflict that is infiltrating all of his/her work; a conflict which initially is entirely independent of the conflicts of the particular patient who caused him/her to sound that pitch, despite the fact that this conflict may

subsequently become meshed with the patient's conflicts as the analysis proceeds. If some patients cause him/her to sound "middle C" with great volume, if they really run up the decibel level, we can assume that these are the patients whose conflicts resonate with, and may even encourage, the analyst's conflicts.

Now we must make some choices in our model. Our first set of choices would center on what the net effect of the analyst's neurosis is with each different patient. Does the behavior that emerges from the analyst's chronic conflict prevent him/her from understanding a particular patient? If so, we would suggest that his/her neurosis is crippling the capacities of his/her analyzing instrument with that patient. Or, does it help him/her to understand a particular patient? If so, we would suggest that his/her neurosis has become subordinated, for the time he can use it in that way, to his/her analyzing instrument. If the first situation is in effect, the one where his/her work is impaired by his/her conflicts, we would need to ask two further questions. Is the nature of his/her impairment limited to his/her finding it difficult to develop an internal empathic model of his/her patient? If so, we would still only wish to describe this as an interference in his/her analytic capacity as a result of his conflicts. Or, is the nature of his/her impairment such that it leads to taking destructive actions with the patient? If this is the case, we would need to ask yet a further question. Does the action he/she takes in the treatment compromise the transference neurosis by inappropriately gratifying the transference? If it does, we would call this countertransference; however, if it interferes with the treatment, *but not in that particular way*, we would only identify it as bad therapy because of the striking differences in how such things affect patients when the transference neurosis is not compromised.

Actually, the way these things usually happen is considerably more complicated because most analysts, while having neurotic conflicts of many sorts, usually are not often so clinically disturbed that they have to act their conflicts out with every patient who comes along. This is, after all, one of the purposes of each analyst's own training analysis: not that he/she should not have conflicts, but that he/she should not be in such poor control of them that they spill out everywhere. (Also, unless we have specific evidence to the contrary, we should assume that analysts can effectively do analytic work even if they have conflicts; it seems an unnecessarily pernicious and cynical attitude - a derivative of the superego's most un-neutralized aggression - to start with the assumption that, because analysts are known to have conflicts, the analyst's motives should always be suspect, and he/she is most likely to behave in an unhealthy way, unless he/she has "proved" otherwise.) The more typical situation is that the harp of the analyst is either silent or softly sounding lots of pitches when the patient enters the consulting-room. However, there are certain situations in which the analyst notices that something is awry in his understanding of, or in his/her reaction to, or in his behavior with a particular patient. Also, he/she notices this with many patients. But, what seems to be happening is that one patient causes the "C" <u>above</u> "middle C" to sound, whereas a different patient causes the "C" <u>below</u> "middle C" to sound. Each patient, then, triggers-off <u>different</u> conflicted responses in the analyst. We can say that, dynamically, one aspect of the analyzing instrument has recognized that something is amiss in the analyst's reaction, and this causes him/her to become consciously aware that something is wrong (even if he/she is not immediately able to identify what it is). The analyst is greatly helped in understanding his/her reactions, and what they mean for the patient, by the fact that different strings on the harp were involved. It is as if he/she says to himself/herself: "With all the different "C" strings I have on my harp, how the did patient manage to pluck this particular one, instead of any other?" Whether the analyst's appreciation of the patient was interfered with (in which case we are speaking of the analytic instrument), or whether he/she was unconsciously gratifying a patient's transference demand (in which case we are speaking of countertransference), the analyst is prompted by his/her recognition to begin the self-analysis that will complete his/her rough early understanding that something was going wrong. In the former case, he/she will enhance his/her ability to analyze when the analysis of his/her reactions is successful, and in the latter case, successful analysis of the situation will enable him/her to stop his/her countertransferential acting out.

The analyst can also make good use of knowing which particular "C" string on his/her harp resonated

with the patient's conflicts. This is the way that an analyst who has stopped being in countertransference can put having previously been in countertransference to some good use, instead of just writing it all off as something unfortunate that he/she hopes not to repeat. Sometimes examining the countertransference (only possible, in my opinion, after the fact - not while one is still in it) is an important way one can learn certain things about the patient. At other times it may be the only way we can learn certain things about the patient. And frequently, it is the key that unlocks the deeply hidden transferences that sometimes exist in an analysis. It has the special capacity to make obscure transference postures visible because countertransference is the complimentary partner to the patient's transference (another good reason for wanting to define it in a way that keeps it related to the analyst's behavioral reactions to the patient's transference).

Final Comments

In trying to address questions about the difference between the inner life of the analyst and countertransference I dispute the assertion that underlies the condensation between countertransference and the analytic instrument that has been popularized by many recent theorists; that is, that countertransference may be a value-free concept. Because it has had negative connotations since it was first conceptualized I think that, despite efforts to view it as neutral or even as something positive, it still retains a negative valence in the unconscious. Listen once again to the language Freud used - "*forces that drag the analyst down from the analytic level*" - this is language that has the ring of compromise formation, and the ring of the superego, about it. In making final case presentations analytic candidates today, just as in previous generations, are extremely careful to strike a balance between what they report about their countertransferences and what they withhold - wanting to be seen as being in touch with how their conflicts have impacted on the treatment while, simultaneously, not wanting to be seen as having been, too often or too deeply, in countertransference.

I think that analysts who try to approach countertransference as if they did not have unconsciously anchored negative attitudes determined by this concept's history in psychoanalysis, attitudes which are immune to conscious secondary process reasoning, are ignoring how conscious ideas remain infiltrated by unconsciously conflicting negative superego attitudes. When the concept of countertransference is linked to, or made indistinguishable from, the concept of the analytic instrument I believe that our thinking about the affectively-rich internal environment of the analyst - an environment that permits understanding, empathy, insight, sensitivity, and intuition - becomes negatively affected by unconscious feelings of shame and guilt that are, and always have been, associated with countertransference.

I am suggesting that no internal reaction of the analyst, whether facilitative of the analysis or disruptive, should be discussed as countertransference. I would do away with the idea that the analyst has countertransference feelings: I would say instead that internal states of the analyst belong to the analytic instrument which is either operating effectively or is impaired. Thus, one does not have countertransference reactions, one has neurotic reactions, and it is only when they are transformed into behavior that we think about whether or not the analyst's conduct is countertransferential.

In considering the difference between the inner life of the analyst and his/her actions I have described how active conflict has the capacity to be extremely helpful, and I have not shied away from describing conflicts that impair the therapy as destructive. I may be best able to consolidate what I am trying to get at in this paper by asking the following rhetorical question: if we acknowledge the role that even neurotic conflict plays in enhancing the analyst's sensitivities; and, if we no longer view only the unconflicted parts of the analyst's personality as the heart of the analytic instrument; and, especially when we are not referring to any destructive behavior of the analyst; what possible advantage is served by describing the mental operations that enhance the analyst's capacity to better understand his/her patient as a form of countertransference?

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