COUNTERTRANSFERENCE REVISITED

Jon Mills

A female patient of mine recounts her week. I listen with interest, waiting for her to arrive at particular conclusions. She has suffered a great deal and still does, but prefers not to dwell on it. My interest turns into patience as she continues to talk but circumvents her discontent. She is adroit at avoidance, but easily offended when I point such things out. "I'd better wait" I think. I grow more aware that I must encourage her digressions. I feel frustrated. Getting further and further away, she skirts the issue with supple grace, then strays off into tangentiality. I forget her point and lose my focus, then get down on myself. The opportunity is soon gone. I glance at the clock as her monologue drones on into banality. I grow more uninterested and distant. There is a subtle irritation to her voice; a whiney indecisive ring begins to pervade my consciousness. I home in on her mouth with aversion, watching apprehensively as this disgusting hole flaps tirelessly but says nothing. It looks carnivorous, voracious. Now she is unattractive, something I have noticed before. I forget who my next patient is. I think about the meal I will prepare for my wife this evening, then glance at the time once more. Then I am struck: Why am I looking at the clock? So soon? The session has just begun. I catch myself. What is going on in me, between us? I am detached, but why? Is she too feeling unattuned, disconnected? I am failing my patient. What is her experience of me? I lamentingly confess that I do not feel I have been listening to her, and wonder what has gone wrong between us. I ask her if she has noticed. We talk about our feelings, our impact on one another, why we had lost our sense of connection, what it means to us. I instantly feel more involved, rejuvenated, and she continues, this time with me present. Her mouth is no longer odious, but sincere and articulate. She is attractive and tender; I suddenly feel empathy and warmth toward her. We are now very close. I am moved. Time flies, the session is soon over; *we* do not want it to end.

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Countertransference used to be considered a very undesirable—even pathological—aspect of the therapist's internal experience of the patient. Among many forms of mainstream therapies today, it is still seen as a detriment when evoked or encountered, a dirty word. Nonanalytic clinicians prefer not to discuss such matters, and when they do arise, it is either viewed as an unsavory dimension of the therapist's prejudicial attitudes, or it is shirked as an extraneous variable, thus irrelevant. Moreover, many clinicians prefer not to disclose their innermost feelings and conflicts with other colleagues, let alone with their patients, out of fear that they will be negatively judged, exposed, and professionally criticized. In the professional analytic literature, however, the question, nature, and meaning of countertransference continue to be among the most heavily contested theoretical and clinical phenomena.

Throughout this article, I examine classical through contemporary analytic perspectives and argue that countertransference is best understood within an emergent dialectical framework of intersubjective relations. While I do not intend to offer an inclusive account of countertransference, I do wish to highlight a few important theoretical considerations under contemporary scrutiny and therefore champion clinical recommendations that have to do with the therapist's experience. I believe, like many others, that facing and understanding one's own countertransference can largely determine the efficaciousness of successful therapy. This is particulary germane when working with characterologically disordered patients. Rather than shy away from one's inner conflicts and dynamic processes that are indubitably bound to spill over into the therapeutic matrix, I feel it is incumbent upon clinicians to embrace their own processes—no matter how sordid or unrefined—rather than repudiate them under the illusion of transcendence in order to manage, if not eclipse, the destructive elements that besiege a successful treatment. After offering a comprehensive spectrum of various countertransference reactions that often beset the analyst, I then turn to the role of projective identification as unconscious communication and offer general strategies for transmuting countertransference.

PERSPECTIVES ON COUNTERTRANSFERENCE

> We have become aware of the "counter-transference," which arises in him 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.
>
> —Freud, "The Future Prospects of Psycho-Analytic Therapy"

Freud said very little about countertransference, but he implied that it was based on pathological manifestations as a result of the analyst's own unresolved conflicts and hence was an obstacle to treatment. In "Observations on Transference-Love," Freud (1915) further speaks of the need for restraint of the analyst's desire and for abstinence regarding the patient's gratification of love in order to keep the countertransference in check. It was not until the 1950s, however, that countertransference began to garner more attention among the psychoanalytic community.

Paula Heimann is generally credited as the first definitive contributor to the literature wherein the analyst's countertransference was viewed as constructive rather than entirely pathological (Langs, 1990). Heimann (1949) tells us that although the analyst's experience of countertransference is largely troublesome and in need of self-analysis and rectification, it also can be used to help understand the experience of the patient. Rather than perpetuate the avoidance and anxiety associated with countertransference discussions among professional colleagues, Heimann's contributions helped lift the taboo on this topic. Before this, analytic clinicians were inclined like emotionally detached androids, shutting themselves down and feeling nothing but manufactured benevolence in order to avoid their own inner processes by remaining focused, albeit illusorily, on the patient's experience. It is no wonder why the psychoanalyst used to be depicted as a cold, staid inhuman "blank slate" that emitted no personal feelings.

Ironically, it was Ferenczi (1933) who readily acknowledged that the therapist has myriad emotional responses to the patient, and that he at times should express them openly, a concept that has gained wide acceptance among contemporary relational analysts today. However, this was not readily accepted by the main-

stream of his day. Heimann (1949), on the other hand, recognized the value of the analyst's emotional responses to the patient and advocated it as a profound tool in understanding the patient's subjectivity, especially as "an instrument of research into the patient's unconscious" (p. 140). Not only should we turn our "own unconscious like a receptive organ towards the transmitting unconscious of the patient" (Freud, 1912b, p. 115), we should especially cultivate an emotional sensibility (viz., allowing free emotional responses to flourish) in order to be attuned to the emotional resonance states and unconscious fantasies of the patient.

Heimann's (1949) view of countertransference was a one-way relation: It was seen as "the patient's *creation*, it is part of the patient's personality" (p. 142). This surely cannot be entirely the case, but her ideas nevertheless stressed the value of the therapist's inner emotional reactions to the analytic relationship as a vehicle for understanding the dynamics of treatment.

Annie Reich (1951) was one of the first analysts to focus on the intrapsychic dimensions of transformation in overcoming the disruptive factors of countertransference. Like analysis itself, what she advocates is the ability to face our own unconscious and use it as a tool for therapeutic transmutation. Just as transference is a projection onto the doctor, so countertransference is a projection onto the patient by the analyst himself. In effect, the patient becomes an object of the past for the clinician's attitudes in the present. Countertransference is based on an unconscious identification with something in the patient that, like a mirror, reflects back something that is intolerable. A therapist's task in overcoming the countertransference is to achieve a sublimation of his conflicts through "desexualized" psychological insight into the patient and into himself, which transforms impulses toward acting-out into the higher faculties of reason necessary for mutual understanding and change—which is what analysis is all about.

In her seminal paper "Counter-Transference and the Patient's Response to it," Margaret Little (1951) further advanced our understanding of countertransference as an intensely interactional phenomenon. She saw countertransference as potentially encompassing any of these four dimensions:

(a) The analyst's unconscious attitude to the patient.
(b) Repressed elements, hitherto unanalysed, in the analyst himself which attach to the patient in the same way as the patient "transfers" to the analyst affects, etc., belonging to his parents or to the objects of his childhood: i.e. the analyst regards the patient (temporarily and varyingly) as he regarded his own parents.
(c) Some specific attitude or mechanism with which the analyst meets the patient's transference.
(d) The whole of the analyst's attitudes and behaviour towards his patient. This includes all the others, and any conscious attitudes as well. (1951, p. 144)

Here Little emphasizes a two-way relation, namely, the inseparable relation between the patient's transference projections and the analyst's unconscious and conscious reactions to them. Little argues that countertransference has both normal and pathological variants, and these variants are proportional to what is elicited by the patient and the unique contingencies of the analytic dyad. Little unequivocally emphasizes the interpersonal, intersubjective, or relational dimension to countertransference phenomena and argues that no countertransference experiences are the same. What she means by this is that every countertransference reaction is different for it resonates within the therapist in peculiar ways that stand in relation to his own disposition and certain aspects of his personality. In fact, Little sees countertransference as a compromise formation whereby projection and introjection play a significant role. Here she alludes to Bion's notion of projection identification as the identification and incorporation of a piece of the patient's projective fantasies. Little rightfully shows how the patient becomes the object for the analyst's conflicted fantasies and unconscious urges, and not merely the other way around. Her work on this subject is so rich with relational nuance, complexity, and insight into the therapeutic situation that it is surprising that her ideas are so underrecognized.

While Heimann (1949) saw all responses to the patient as countertransference, Tower (1956) defined countertransference as the analyst's transferences to the patient. In fact, Tower privileged countertransference as an "*emotional understanding*" (p. 165) of the patient's transference neurosis. Winnicott (1949), on the

other hand, mainly spoke of "objective countertransference" as "the analyst's love and hate in reaction to the actual personality and behavior of the patient based on objective observation" (p. 70), the term "objective" being in desperate need of an operational definition; while Ferenczi (1950) preferred to focus on the affectionate, positive, loving, and/or sexual attitudes one takes up toward the patient, a point Balint (1950) highlighted by returning to Freud's (1912a) observation that every human relation is libidinous. Harry Stack Sullivan (1949) emphasized the analyst's "parataxic distortions" of being "in participant observation of the unfortunate patterns of his own" (p. 12), patterns that Cohen (1952) claimed were always derived from the presence of anxiety in the analyst. This issue led Frieda Fromm-Reichmann (1950) to distinguish between the personal and professional responses of the analyst under the influence of countertransference, a position that brought Alexander (1948) and others to ultimately conclude that countertransference is simply any and/or all attitudes the analyst has toward the patient.

Racker (1972) perhaps provides the most comprehensive consideration of countertransference in the classical literature, showing the inextricable nature of intersubjective processes in the therapeutic dyad, including the projective elements of the analyst's transferences and the identificatory aspects of the patient's responsiveness to the analyst's projections as an interactional pathology. He is particularly perspicacious in highlighting the defensive functions of the clinician's reticence in addressing countertransference in both professional and personal space.

Racker distinguishes different forms of countertransference, namely: (1) *concordant identifications*, which involve the therapist's identification with a patient's internal object or self-state, such as the analyst whose ego or superego identifies with the ego or superego of the patient; and (2) *complementary identifications*, whereby the patient treats the analyst as an internal (albeit projected) object, which the analyst himself assumes, that is he identifies himself with this object. Racker further distinguishes countertransference experiences within two classes: (3) *countertransference thoughts* or fantasies, and (4) *countertransference positions*, or the behaviorally manifested or enacted roles, which

may lead to persistent role-adoptions and/or acting-out by the analyst.

While Gitelson (1952) describes countertransference as "partial" reactions to the patient, Heimann (1949) views countertransference as a phenomena that "cover[s] all the feelings which the analyst experiences towards his patient" (p. 140), a view that Kernberg (1965) refers to as "totalistic" or all-embracing. Kernberg, as does Tower (1956), emphasizes the total emotional reaction of the therapist in the treatment situation, which encompasses both conscious and unconscious reactions to real and fantasized events. Kernberg, as does others, highlights the interactional, hence intersubjective, nature of countertransference as an ongoing interpersonal negotiation between the lived intrapsychic experiences of both parties that form the relational matrix. Here, as with Menninger (1958), the therapist's conscious experience of countertransference is accentuated, although it may be said to have originated from unconscious determinants. Kernberg (1965), and later Masterson (1983), alerts us to the potential danger of countertransference fixations, which typically correspond to regression in patients during analysis. In effect, the more primitive or neurotic dimensions of the therapist's personality become overidentified as "counteridentification" with the patient's regressed psyche, and a resurfacing or repetition of the analyst's own conflicted character traits are superimposed on the therapeutic process.

There is still contemporary debate regarding appropriate definitions of the term "countertransference" and its implications for the consulting room. Eagle (2000) argues against past and current popular trends to equate anything and everything the analyst thinks or feels toward the patient as countertransference. In fact, there is so much confusion about what exactly constitutes countertransference that some advocate abandoning the term altogether (Aron, 1991; McLaughlin, 1981). To the extreme, there are some intersubjective theorists who readily object to the whole phenomenon of countertransference, claiming instead that there is no such thing within an intersubjective system of mutually regulating interactions and reactions. However, despite the fact that there are arguably cotransferences that transpire in

the session as well as in everyday interpersonal life, I find it important to retain experiential distinctions between the analyst's transference toward a patient and the analyst's actions based on how such transferential phenomenon is subjectively filtered, interpreted, distorted, and acted upon during a therapeutic moment within the analytic milieu. Just because a therapist experientially processes an unconscious artifact that by definition applies to all people in every interpersonal situation does not mean that the therapist will act on such transferences in such a way that they obfuscate the coming to presence of the analyst's developmental intrapsychic history with the urge to act during the immediacy of the clinical encounter. In other words, one can become perfectly aware of transferential forces operative within the analytic moment without the felt compulsion to behaviorally execute them. It is for these reasons that I find it both pragmatic and necessary (as a technical principle as well as for theoretical purposes) to maintain conceptual nuances between the analyst's transference to the patient and the analyst's countertransference, the former being a universal dynamic of every relational encounter, and the latter a therapeutic enactment.

In a recent article titled "Countertransference and the Analytic Instrument," Richard Lasky (2002) judiciously distinguishes between the analyst's internal experiences that impede the therapeutic process verses those that facilitate it, albeit the criterion by which to determine this is not all together clear and is open to multiple interpretations and contingencies. Lasky does, however, distinguish various definitions of countertransference from what he calls the "analytic instrument" by classifying them into general groupings (pp. 69–70). Therefore, it may be helpful at this point to summarize three main kinds of definitions of countertransference generally observed in the psychoanalytic literature, each carrying different meanings and significance depending upon which author or school of thought one consults:

1. Countertransference should be conceived of as a specific response or set of responses by the therapist to the patient's transference relationship to him. Countertransference can be constructive or destructive, healthy or abnormal, and can either help or hinder the treatment, depending upon the de-

gree to which the analyst is capable of bringing his personality to bear on the therapeutic process.

2. Countertransference is primarily seen as a dynamic destructive to therapeutic efficacy, marked by the analyst's negative and harmful reaction to the patient's transference. This approach would differentiate between the neurotic or pathological portions of the analyst's personality that are brought to bear on the therapeutic dyad independent of the patient versus those that are specifically mobilized in response to the patient's transference, thus impacting on the analytic work in differing ways. From this view, countertransference is a purely negative phenomenon. It is only in the wake of the clinician's understanding of his pathological reactions that the countertransference can be attended to and overcome, thus moving beyond the throes of the analyst's negative responsiveness that creates an impasse to therapy. Here the analyst can come to use the countertransference experience in a more productive light, which illuminates the unconscious dynamics of the patient; furthermore, such insight can be harnessed as an avenue for engaging the therapeutic encounter in more beneficial and propitious ways. This model assumes that the countertransference can be left behind through a process of self-analysis which then frees the clinician to adopt a more favorable role and attitude toward the patient's dynamics, uncontaminated by the subjectivity of the analyst.
3. Countertransference is tantamount to the inner life and total experiential reaction of the analyst at work in the context of therapy. This is not necessarily predicated on the patient's transferential relation to the therapist, but it certainly encompasses this primordial dynamic. Every part of or dimension to the therapist's personality is potentially at play and evoked in the therapeutic encounter, whether unconsciously organized, expressed, or consciously realized. Based on ego identifications by the analyst, countertransference can have positive and negative valences, is both normative and pathological, and can equally boost or hamper the analytic process.

So after all these decades of debate, do we have a better understanding of countertransference? Or has this concept be-

come so varied, elusive, and/or potentially watered down that it loses its original significance? Recall that Freud identified countertransference as a specific reaction (as internal protest and rebuttal) to the patient's transference. Lasky's solution is to make the analytic instrument the means, method, and expression of the analyst's subjective inner condition, thus drawing on the therapist's entire personality but not to equivocate or equate the analyst's personality with the therapeutic sensibilities he brings into the consulting room. Neither the preexisting character structure of the therapist nor everything he experiences toward the patient is countertransference. This view to me seems correct. There is a big difference between what the clinician experiences internally in the context of treatment and what he does with such experiences, both intrapsychically and through behavioral enactments. This can make all the difference between using the countertransference as a therapeutic corrective versus conducting and perpetuating bad therapy.

But this still leaves a conundrum. If we are to adopt the criterion that the therapist's conduct versus his inner experience is the defining characteristic that distinguishes countertransference from the analytic instrument, then how are we to reconcile the enactment of countertransference when by definition behavioral comportment is internally mediated by the analyst's subjectivity? While inner subjective experience is a necessary condition for therapeutic action, are we conceptually justified in bifurcating thoughts, fantasies, intentions, beliefs, and attitudes (viz., the domain of the analyst's intrapsychic activity) from the expressed behavioral manifestations that inform his interventions (e.g., body posturing, nonverbal cues and communications, physical gestures, emotional utterances, and verbal, linguistic expression)? Are the inner motives, unconscious emotional resonance states, neurotic evocations, internal precipitous reactions, and the conscious understanding and reconciliation of such processes capable of being separated from countertransference based on behavioral activity alone, when these behaviors are predicated on such mediated inner experiences to begin with?

Perhaps we can only make the distinction between countertransference (as behavioral phenomena) and the analytic instrument[1] (as subjective agency) by looking back at the process retro-

actively to see how the therapist's internal attitudes and emotional reactions affected his therapeutic demeanor. This would make the criterion of what justifiably constitutes countertransference a process of intersubjective mediation and not necessarily a solitary one performed by the therapist alone. This process involves a twofold dialectical relation between each subject in the intersubjective system, which in turn generates a new phenomenological field in the treatment process, what Beebe, Jaffe and Lachmann (1992) call a "dyadic system" of reciprocal mutual influence, what Stolorow and Atwood (1992) call the "intersubjective field," or what Odgen (1994) refers to as the "analytic third."

From the standpoint of the analyst's subjectivity, there are at least three levels of self-reflective mediation required: (1) The clinician needs to be introspective enough to discern and identify various internal disruptions that are potentially motivating or fueling tendencies toward certain interventions, in order to contain (or at least curb) acting-out episodes from transpiring in the first place. (2) There is a need to self-monitor one's precipitous reactions, internal resonance states, and overt behaviors that directly affect the patient and the emergent, altered intersubjective system. (3) The clinician must be self-reflective enough to examine one's own past actions that have affected the therapeutic climate in order to make various correctives or reparation within the treatment itself. (Because countertransference phenomena are largely unconsciously motivated enactments, it is often the case that until such unconscious motives are consciously realized do we have more insight and mutative control over their instantiations.) Yet this process of observing and ameliorating countertransference is contingent on the patient's receptivity and subjective response to the therapist's interventions through ongoing relational exchange and interpersonal negotiation. Even though an analyst may be internally motivated to act out his countertransference behaviorally, becoming aware of it and modifying one's behavior beforehand would limit the countertransference tendency before it detrimentally spews over into the analytic process. But even if it does, the patient may or may not experience the analyst's countertransference as detrimental per se; perhaps conversely, it may facilitate moving the treatment into auspicious directions. This makes the criterion of de-

termining the impediment or efficacy of countertransference an intersubjective phenomenon and not necessarily one based on either the therapist's internal experience of the patient alone or his unconsciously motivated determinants and conscious intentions that govern overt interventions.

Whether we are considering the patient's view of the analyst's attitude toward the patient (Gill, 1983), the patient's interpretation of the analyst's experience (Hoffman, 1983), or the patient's experience of the analyst's subjectivity (Aron, 1991), we must include the patient's intrapsychic *and* relational stance toward the inner life of the therapist (and vice versa) in our equation of what constitutes countertransference. This is why countertransference cannot be dissected or removed from the intersubjective environment of therapy and exclusively attributed to the analyst. Furthermore, it ensures that countertransference is not something that can be overcome, because we are always embedded in a relational ontology. This is a reason why I prefer to view countertransference as a mutative and transforming interpersonal phenomenon rather than one that is solely attributed to the "affectively rich internal environment of the analyst" (Lasky, 2002, p. 93). Countertransference is an ongoing trajectory of relational exchange that can be seized upon and continually altered, revamped, and reincorporated into the variegated nuances of treatment, which is always in flux as a process of becoming. This means that as certain countertransference processes are evoked, sustained, transmuted, and surpassed (yet simultaneously preserved), they are reconstituted in other intratherapeutic forms or replaced by ongoing, overlapping, and overdetermined multiplicities of mutually interjective psychic processes within intersubjective analytic space. We cannot get behind or beyond countertransference by virtue of the fact that it is part and parcel of the relational matrix.

In countertransference, there is always something that is not said, the presence of absence—of negation—of "the *not*." Countertransference is a call to embrace our inner being in the mode of its immediate appearance within the moment of felt resistence to or from the Other—in the moment of being bombarded with otherness to the point that it fractures our secure little world we have hitherto made for ourselves in our preferred

pathways of defense. We often experience countertransference as an assault on our inner being—on our self-integrity—that repudiates our essence. But countertransference is the coming to presence of a co-constructed reality where no single agency manufactures it alone: It materializes out of the moment-to-moment tensions of broaching psychic union with the other's subjectivity. In this sense, countertransference, like transference, is a resurfacing, a *re-presence* (as re-presentation) or reintroduction of the interjection of our being into the being of the other.

FACING COUNTERTRANSFERENCE HONESTLY

Throughout my first analytic treatment, my analyst, who trained with Bion, had behaved in various ways that were palpable enactments of countertransference. For example, he would frequently eat his breakfast muffin during our session, then attempt to share it with me if he happened to notice I was looking at him while he ate his food. On one occasion, he failed to show up for our scheduled appointment. Later he told me he had slept through our appointment time because he was jet-lagged from returning home from a trip. Another time, he lightly dozed off in the session, then denied that he had fallen asleep even though I had to wake him. After these events, he started to invite me to his condominium for sessions rather than his office. I recall the sense of specialness I felt being privileged to be in his home, only to find his reluctance to turn off the ringer to his phone a constant source of interruption. When I brought these incidents to his attention, I asked him if he felt his actions were due to his countertransference. I had suspected that he had resented taking me on as a graduate student for a reduced fee. When he acknowledged that this could be happening, I asked him if he would share it with me, but he declined. He told me that he did not work that way, but he would think about it. Although frustrated, I was respectful of his candor and saw the necessity of preserving the asymmetry of the relationship through a firm boundary. It is only in retrospect that I feel he should have handled the matter differently.

What becomes a hindrance to the patient's growth is the therapist's inability to recognize and understand his own dy-

namic conflicts that spill over into the treatment environment in a deleterious fashion. With this in mind, Freud's (1910) attitude is as prevalent today as it was a century earlier: The analyst must "overcome" the countertransference. We often hear of caveats for working-through the countertransference, as if it is something we can put "behind" us. Natterson (1991) further tells us that we can get "beyond" countertransference through self-scrutiny. But is this possible? Is it possible to overcome or get beyond our human condition—our subjectivity? These propositional attitudes view countertransferences as only an interference to treatment, when they can potentially become an ally to understanding and facilitating a better treatment approach to our patients. Little (1951) supports this claim: Countertransference "cannot be avoided, it can only be looked out for, controlled to some extent, and perhaps used" (p. 151). Well, it certainly can be used. I am under the persuasion that it is not possible to overcome or even transcend our countertransference because we are always immersed in it. Instead, we must *embrace* our countertransferences in order to transform them—not to transcend[2] them, which is neither possible nor practical, but rather to accept, incorporate, and evolve them through self-reflective mediations.

The phenomenology of our inner subjective experiences and prejudicial dispositions will always saturate the clinical encounter, and no amount of self-deception or professional instruction will eradicate this fact.[3] Likewise, no amount of therapy or personal analysis may erase countertransference, for these processes are as natural as breathing and continue to be fueled by the therapist's unconscious emotional resonance states and/or neurotic proclivities that repetitiously resurface in conscious life. Equally, countertransference is not in and of itself an anomalous quality or emergent property of therapy that can be tabled, bracketed, or completely abandoned. Countertransference is nothing other than the phenomenal manifestation and admission of being human, which commands us to acknowledge our own lived subjective reality by observing and nurturing our unconscious disruptions. Just as transference is a ubiquitous phenomenon of every interpersonal encounter, so is countertransference: Both are equiprimordial processes. Countertransference

is a communication to the self that speaks to us when we increasingly draw our attention to it. We can never come to sufficiently know all our unconscious "blind spots," just as certain surreptitious satisfactions of infantile needs will continue to press for fulfillment through the various attitudes and reactions we come to harbor toward *all* patients. Here I wish to emphasize the need for professional and personal honesty: Although the psychoanalytic community had long ago recognized the value of countertransferential acknowledgment, the psychological community in general needs to recognize and openly admit that countertransference is a natural phenomena—not an inherently pathological one, and therapists need to put aside the veneer of denial, secrecy, or fear of exposure or admonition by professional colleagues, to stop pretending that they are "above" or "beyond" falling prey to their unconscious shortcomings.

Countertransference is never left behind through a process of self-analysis—as if you could think it away—like you could liberate yourself from your humanism, your subjectivity, whether pathologically motivated or not—in order to achieve a state of unadulterated responsiveness and sensitivity to the patient's need for wish-fulfillment. What we may optimally strive for is to embrace and immerse ourselves in our countertransference, to repudiate yet savor every emotive moment, to grapple with and attempt to understand it courageously, and once this is sufficiently achieved, to transform our facticity through determinate freedom, what the ancients would call wisdom.

The didactic training of therapists today is riddled with the pretentious, illusory belief that a certain skill or technique, when delivered correctly, is the right, absolute standard upon which to judge the success or failure of an intervention. We all know this is not the case, but we placate the instructor, supervisor, or training analyst in order to assuage their narcissism, receive their praise, and get our degrees so we can practice autonomously without having to remain enslaved to the concessions of authority. Many students—perhaps most—are terrified to be honest to their supervisors about their true thoughts and feelings when treating patients because of the fear of negative evaluation, condemnation, and potential retaliation, such as failing their course, practicum placement, or candidacy as an analyst in training.

They are also adept at adopting a false self in order to appease the supervisor because they intuit or know that the other expects a certain degree of compliance and conformity to his wishes. They also know when the professor or supervisor is pretending or lying about a professed belief, attitude, or sensibility that he cannot possibly uphold, let alone expect others to emulate. Here I have in mind the need for the profession to repeat inauthentic platitudes such as the need to cultivate a presentation of altruism and respect (if not unconditional regard) that we should all possess in order to be good therapists, and that negative dispositions about our patients only point toward a limited or pathological person who has no business being in the profession. The admission of extreme negative feelings about a patient is typically met with consternation if not moral reproach for being so brazen (and remiss) in offering such a candid confession. As a result, students and clinicians alike are discouraged from discussing their true feelings in professional space (e.g., the classroom, supervision, conferences, journal publications) due to a culture of dishonesty and fear that is promulgated from within the academy and analytic institutes regarding standards of training and professional identity. As a profession, we must cease being phobic and disingenuous with ourselves about our conflicted feelings and difficulties in working with patients, and equally we must stop being paranoid that countertransference is an unwelcome, taboo subject not capable of being professionally discussed openly among colleagues.

How often do we hear psychotherapists admit their profound hatred or uncontrollable lust for patients in the presence of other therapists? Not often. When we do, we are careful in what we say, let alone disclose in turn, only then to wonder about the ramifications of such conversations. I once had a colleague confess that the way he discharges his rage for certain patients is to imagine their faces as he chops wood for his fireplace. On other occasions, the uninhibited comfort in discussing vivid and lurid sexual fantasies about various patients proved to be powerfully transformative and containing. We all know that it is not uncommon for therapists to masturbate while thinking of certain patients or fantasize about them during sexual intercourse with their partners. Under these circumstances, forbid-

den wishes may be fulfilled through circuitous displacements that transfigure and convert the countertransference into manageable forces that are more safe, curbed, subdued, and restrained, hence prevented from being acted out.

It is not enough to merely become aware of one's countertransference feelings toward patients; they must be understood within an ongoing climate of self-scrutiny and self-analysis, thereby linking the present experience in the clinical encounter to dynamic vulnerabilities from one's own past and character structure, in order to transmute them within the interpersonal medium of therapy so as to affect and bring about a new mode of therapeutic relatedness. But how is this possible?

THE SPECTRUM OF COUNTERTRANSFERENCE PHENOMENA

When contemplating countertransference, we often think of extreme emotions or impulses that are aroused, such as the dialectic of love and hate, which hinder our capacity to treat our patients in the most competent and optimal manner. This is far from the case. There are benign and malignant countertransferences just as there are forms of cancer, yet each may potentially have a detrimental effect on the success of therapy if they go unnoticed and merely enacted through the guise of personal mannerism, preference, or intersubjective therapeutic play.

Countertransference enactments are as myriad as possibility itself. Boredom during the session, for example, is one of the most universal manifestations of countertransference: even when the patient is legitimately boring, the mere fact that the clinician remains on the level of banality points toward a failure to intervene. We may even observe the opposite scenario: Lacan would tell his patients that he was bored five minutes after the session begun, blame it on them, and then ask them to leave, thus passing off his invalidation and rejection as a legitimate technique he called "scansion."

Within the clinical literature, we may readily observe a preoccupation with various forms of countertransference phenomena that continue to summon our attention, such as the analyst's denial and repression (or re-repression) as resistance to his countertransference; the inability to understand certain kinds of ma-

terial because it touches on one's own vulnerabilities and personal problems; depressed or uneasy feelings before or after the session; the propensity to act out hidden unconscious conflicts that neglect the patient's welfare; dislike as a failure to understand the patient; inability to restrain verbalizations of one's annoyance, anger, or direct outbursts; the need to enter into competition with patients—like getting into critical arguments or belittlements, engaging in rationalization or staying on the intellectual level as a way of avoiding emotionality; even the sadistic withholding of reassurances and validation or, conversely, overly consoling and gratifying patients in response to anxiety. Countertransference has no bounds, which may appear in a variety of forms, from a sense of total dedication to a patient, exploiting the erotic transference, to feelings of emotional discontinuation, micro-paranoiac attitudes, paranoia as the mobilization of strong aggressive impulses toward the patient, and feelings of regression, dissociation, fragmentation—even transitory psychosis—as an overidentification with the patient's regressed or decompensated clinical condition.

Although the phenomenal qualities and nuances of countertransference are different from therapist to therapist, for didactic purposes it may prove useful to examine the more miscellaneous forms of countertransference we commonly encounter. While neither exhaustive nor inclusive, the following is a list of potential countertransference phenomena (unconsciously motivated yet typically manifested as qualia of consciousness) that clinicians should be alert to. I have categorized them in terms of subjective experiences therapists may notice during (1) *therapeutic enactments*, that is, as behavioral instantiations pertaining to the session, as well as various thoughts, feelings, and fantasies that materialize and coalesce around experiential self-states such as the presence of (2) *passivity*, (3) *anxiety*, (4) *aggressivity*, (5) *eroticism*, and (6) the *narcissistic vulnerabilities* that are evoked in the analyst during the therapeutic encounter. These countertransferences do not necessarily need to be grouped into these thematic categories, nor are they inclusive to these experiential self-states. Countertransference phenomena cross over into a wide array of therapeutic contingencies and subjective experiences that have multiple, overdetermined meanings and significance governed

by the unique personality constellations of the therapist–patient dyad: It is only for descriptive purposes that I list them here in this fashion:

TABLE 1
Six Categories of Countertransference

Therapeutic Enactments
- accepting what the patient tells you at face value
- carelessness with regard to patient arrangements
- forgetting about a patient's appointment time
- arriving late for the session
- allowing the session to go over the time alloted
- not charging for no-shows or late canceled appointments
- letting patient accumulate a large bill
- overcautiousness or therapeutic overeagerness
- avoidance of direct discussions
- inability to analyze, think critically, or address resistances
- mistimed or wrongly emphasized interpretations
- patient's misunderstanding of therapist's interpretations
- being hesitant, reticent, or not firm
- taking on passive, obsequious, or masochistic role
- failing to address maladaptive defenses
- fear of confrontation
- need to elicit affect from patient (i.e., via provocation or drama)
- parapraxes, significant slips, or faulty achievements
- didactic, authoritarian, playing role of expert
- prolonging treatment when therapeutic goals have been achieved
- inappropriate self-disclosure

Passivity
- unevenly suspended attention
- inattention, distractability
- difficulty in concentrating and/or remembering
- inability to identify with patient
- persistent drowsiness, somnolence, dozing off
- uninterest, boredom
- indifference
- insouciance, apathy
- lassitude, lethargy
- aloofness
- preoccupation with other matters or personal affairs
- daydreaming

Anxiety
- laughing readily or out of context
- verbalizing spontaneous thoughts
- confusion
- avoidance
- helplessness
- lack of confrontation, evasion
- overt anxiety in the session
- feeling intimidated
- carrying over affects from the session
- premature reassurances to defuse the experience of anxiety in the patient
- inability to gauge points of optimal frustration
- dreams about patients (especially involving acting-out episodes)
- disturbing feelings for the patient
- dread associated with seeing the patient on appointment days or pervasive discomfort during the session
- stereotypical or prejudicial attitudes
- phobic reactions, recognized fear
- masochism (being emotionally abused by the patient)
- paranoiac attitudes
- overconcern about the confidentiality of the therapist's work

Aggressivity
- negation, criticism, invalidation
- overdirectiveness, overactivity
- dissatisfaction, disapproval, dislike, contempt
- aversion, disgust, repudiation, repugnance, revulsion
- frustration, peevishness, scorn, exasperation
- arguing with patient
- becoming increasingly disturbed by patient's accusations and reproaches
- resentment, anger, outrage, rancor, indignation
- rage, wrath
- loathing, antipathy, animosity, abhorrence
- hate/hatred for patient, or self-hatred
- feeling trapped, controlled
- paranoiac fantasies (as projection or introjective aggressive)
- violent emotions, fantasies, daydreams, or dreams
- feelings of revenge/desire for vengeance
- cruelty, sadism
- death wishes

Eroticism
- attention paid to patient's body
- compliments paid to patient's appearance or clothing
- visual orientation toward patient's figure, breasts, legs, or genital area

- special attention paid to one's own appearance, dress, or hygiene before the session
- seductive body posturing or positioning
- initiating self-disclosures about one's personal life
- perceptions of seduction (when dubious or ambiguous)
- unacknowledged flirtation (either sensed, received, or reciprocated)
- idealization of patient's personal qualitites
- avoidance or lack of confrontation regarding sexual matters
- sexual curiosity
- special interest or preoccupation with sexual material in session
- therapist's initiation of discussing sexuality
- voyeurism via encouraging detailed explication of patient's sexual fantasies
- suggesting extratherapeutic contact
- invitation to social functions
- giving patients cards or gifts
- titillation or sexual excitement
- feelings of lust
- direct or overt eroticization
- sexual fantasies or dreams
- homosexual thoughts/revulsion, homophobia
- therapist self-disclosure with regard to personal relationships, including feelings for the patient
- falling in love with the patient

Narcissistic Vulnerabilities

- excessive preoccupation about patient outside of session
- talking about oneself, one's accomplishments, and so on, out of context
- seeking to impress the patient
- need to get assurances/praise from the patient
- increased need for gratification
- overidentification with/idealization of patient (e.g., the analyst's "best" patient)
- jealousy/envy
- feelings of competition
- manufactured arguments or debates
- feelings of superiority
- entitlement
- guilt
- shame
- narcissistic injury, narcissistic rage
- need to see patient as special
- becoming object of unbridled adulation or idealization
- being overconciliatory—overly gratifying or reassuring
- need for patient to identify with therapist
- tendency to think that patient should be like therapist (at expense of own individuation)

- asking patients for favors
- helping patient in extratherapeutic ways (e.g., giving practical advice, helping secure a loan)
- patient used as mirroring selfobject
- intolerability of patient autonomy or self-assertion
- dependence on patient's narcissistic supplies
- encouraging illusions about analyst's therapeutic prowess as healer (e.g., as the magic cure)
- engaging in exhibitionist, professional gossip or boasting about a patient
- feeling that the patient's recovery and health reflects therapist's reputation and prestige

We must admit that the compendium of countertransferences listed above are highly specific to each analyst's peculiar subjectivity within the contextualization of the therapeutic milieu; therefore a universal application to all clinicians would not be warranted. Despite this caveat, we may notice various patterns or thematic repetitions that have a tendency to universally emerge, which lends credibility to countertransference generalizations that may be observed over time regardless of their historical, cultural, and/or gendered instantiations. It is up to the clinical judgment of each practitioner to discern what applies to him or her or is irrelevant.

Although commensurate with many of the countertransference phenomena mentioned earlier, there are certain experiences I notice time and again while treating attachment-disordered populations. Not surprisingly, these countertransference reactions and repetitions tend to echo various attachment styles characterized by ambivalent, avoidant, angry-resentful, dismissive, controlling, disoriented/disorganized, dissociated, and detached behavioral patterns. While these observations may be peculiar to my caseload and my own personality and/or unconscious subjective processes, I offer them as suggestive orienting events that point toward potential countertransference enactments other clinicians may notice or experience. When these experiential self-states arise in the course of therapy, they often represent particular anxieties about the bond and level of connection or trust established between the analytic dyad, which presents as an opportunity to examine the nature of the therapeutic relationship.

TABLE 2
Attachment-Related Countertransferences

Security /Insecurity
- fear of rejection, abandonment, or loss
- fear of cultivating dependence
- fantasies/wishes that the patient will drop out of treatment
- providing unnecessary reassurances as a form of security seeking
- questioning the patient's autonomy
- feelings of instability/precariousness
- helplessness as a failure to intervene
- fantasies of holding, soothing, protecting, or rescuing the patient
- precipitous feelings of love/eroticism
- using patient as a fantasized dependency surrogate
- becoming parental, overnurturing, or overvalidating
- feeling overly obligated or dutiful
- lacking assuredness or confidence in interventions
- naivety about the quality of the therapeutic relationship or the therapist's importance
- being overzealous, too friendly, or worried about appearing nonthreatening to the patient
- fantasies that the patient will not pay the bill

Ambivalence/Preoccupation
- uncertainty, obscurity, abstruseness over feelings for patient
- prolonged confusion/ambiguity about patient's communications
- emotional misalignment
- therapeutic clash due to misperception or misunderstanding
- inability to achieve empathy/vicarious introspection when patient's associations pull for such
- aversion/diffidence
- overpreoccupation about patient
- not thinking about patient at all outside of sessions
- resistance to accepting patient's explanations/associations
- contradictory feelings, inconsistency of attitudes
- fluctuation in mood about patient
- persistent hesitancy, indecision, doubt
- anger, contempt
- passivity

Avoidance/Dismissal
- boredom, somnolence
- apathy, indifference
- focus on problem solving
- tendencies toward intellectualization
- normalizing the patient's experience

- ignoring, averting, overlooking important material or responsibilities
- evading questions
- fantasies of rejecting the client or terminating treatment
- reluctance to examine attitudes and feelings about the patient further than immediate impressions or emotive reaction
- lassitude or inability to confront defenses
- avoidance of intimacy or discussing the therapist-patient relationship
- pessimism about success of treatment
- discouragement, disillusionment, dissatisfaction
- discontentment, despondency
- excessive abstinence
- making excuses for irresponsibility
- discounting patient's experience

Disorganization/Disorientation

- distractability, inattention, inability to concentrate
- facial or gaze aversion
- thought suppression
- bewilderment, feeling perplexed
- feeling head is cluttered
- unremitting confusion
- being lost, dazed, or misguided
- emotional blocking
- freezing up, emotionally barricading oneself
- feelings of incoherence, disjointedness
- feelings of disconnection, discontinuity
- dissociation during the session
- frenzied, haphazard approaches to interventions
- spontaneous, undisciplined interpretations in order to gain reorientation or interest

Detachment

- daydreaming, fantasizing
- withdrawal
- isolation and compartmentalization of affect
- paucity of affect
- lack of emotional involvement
- affective abandonment/detachment of affect (e.g., when the patient is upset, the therapist has no emotional reaction)
- removal of warmth
- pervasive sense of disconnectedness (e.g., disidentification)
- extreme feelings of alienation
- failing to take good process notes
- no interest in seeking out supervision
- feeling as though the patient is a thing, automaton, or clinical object of study

PROJECTIVE IDENTIFICATION AS UNCONSCIOUS COMMUNICATION

In psychoanalysis, there is much complexity in what we mean by identification in its various forms. For Freud (1921, 1933), identification is the earliest form of attachment to an object based on an emotional bond, which involves many introjective and projective maneuvers throughout the process of internalization. In fact, the term identification is used in so many theoretical contexts, it is hard to precisely determine its elemental value in psychic economy. Since Klein's (1946) introduction and Bion's (1962) subsequent modification of the term "projective identification," identification has been primarily employed in the context of defense. Racker (1972) refers to direct, concordant, and complementary identifications in the countertransference with reference to their defensive functioning, and this may be said to extend to other forms of defensive identification such as ego/superego identifications, disidentifications, counteridentifications, introjective identifications, projective counteridentifications (Grinberg, 1962), and so on. When we refer to specific modes of defensive identification, it is important to keep in mind that these are merely temporal intrapsychic phenomena enacted in a particular moment of intersubjective exchange. Just as Lasky (2002) informs us that the convoluted nature and interface between countertransference, intuition, and empathy is highly complex and intertwined, so is the process of projective identification.

The psychic process known as projective identification has become a familiar tenet of psychoanalytic doctrine, yet depending upon which model you consult, the term can mean a variety of different things. Projective identification was introduced by Klein (1946) in the context of splitting, where it was conceived as an aggressive discharge of certain portions of the infantile ego into another (usually the mother) via unconscious fantasy, the aim of which is to control or incorporate certain aspects of the other in order to make it part of the ego's own internal structure. Not only did the introduction of this concept revolutionize Kleinian theory, further developments had paved the way toward its progressive application in understanding a number of

mental processes, pathologies, and clinical encounters. To be sure, projective identification may be viewed in multiple fashions: (1) as a general process of mental activity, from unconscious structure to conscious thought, (2) as a defensive maneuver motivated by intrapsychic conflict, and (3) as an intersubjective dynamic affecting object relations, especially the process of therapy. But with a few noteworthy exceptions (see Bion, 1959), projective identification has been largely overlooked as a basic element of psychic organization.

Elsewhere, I have shown that Hegel's anticipation of Klein's and Bion's theories of projective identification as the process of the self returning to itself due to its own self-estrangement adds to our understanding of both the normative and pathological processes of mind (Mills, 2000). In health and illness the ego projects certain aspects of the self onto the object world, which it then identifies with and finally reintrojects into its own subjectivity. In effect, the self rediscovers itself in the product of its own projection and then reintegrates itself within itself as reunification. This is the generic structural movement of the Hegelian dialectic (*Aufhebung*), whereby internal division, external projection, and reincorporation function as a mediating and sublating dynamic.

While Klein discovered projective identification, which further led Bion to advance the distinction between its normal and pathological variants, Hegel was the first to articulate the formal structural processes of projective identification, with its source and origins within the unconscious mind. Since Bion, a less pejorative attitude toward patients' use of projective identification has been adopted among clinicians, which has further initiated attempts to define different aspects and subtypes of this phenomena differentiated by form and motive—such as the degree of control over the object, the attributes acquired, the need to protect certain positive qualities or to avoid separation, their relation to splitting, the force of evacuation, communication, containment, and so on—all subsumed under a general rubric (Spillius, 1988).

More recently, projective identification has been given special attention in its relation to countertransference and empathy. Tansey and Burke (1989) view projective identification "as a psy-

chological operation with defensive, adaptive, and communicative properties" (p. 44). They affirm a Bionian interpretation as both normative and pathological, as do Malin and Grotstein (1966). Following a Kleinian analysis, Odgen (1982), on the other hand, emphasizes the pathological aspects of projective identification as primitive defense, as does Kernberg (1975). This view has direct clinical utility for working with attachment-disordered populations, since the clinician is often the unconscious target of the patient's projective identifications. For Ogden, the projector is able to induce certain internal states in the object, which the object then metabolizes and gives back to the projector, which in turn is reinternalized. Generally we may say that within the context of therapy, the patient projects onto the therapist certain disavowed and repudiated internal contents that the therapist unconsciously identifies with, such as the behavioral fantasies, attributions, or personal qualities that are the objects of splitting, which the therapist then introjects as a function of his own ego (hence introjective identification), thus leading to conflicted inner states that the therapist must manage. If the therapist's countertransference reactions are too strong and/or remain unrecognized as the internalized projected attributions of the patient, he may potentially act out such negative states within the therapeutic encounter, thus potentially leading to further internal disruptions in both parties, negatively affecting the intersubjective field.

Although projective identification is a psychic process that may be either intrapsychically or intersubjectively evoked and instantiated, it may be helpful to view projective identification as an unconscious communicative process of inducing interpersonal patterns of behavior in the therapist that are designed to have him respond in certain circumscribed fashions. Here the therapist becomes the target and repository of the patient's negative experiences, thoughts, conflicts, and behavioral fantasies, which the therapist unwittingly identifies with and takes into his psyche. As a result, the therapist is unconsciously induced to behave in certain ways in response to the patient's projective identification, which inevitably give rise to countertransference reactions that are triggered as a result of the emotional resonance states aroused and henceforth prodded on toward action. As

Odgen (1982) tells us, the patient desperately wishes to rid himself of a distasteful or threatening piece of psychic reality that endangers the self (including internal objects) by depositing the unconscious fantasy in a powerfully controlling way into the receptacle or container of the analyst's mental apparatus:

> The projected part of the self is felt to be partially lost and to be inhabiting the other person. In association with the unconscious projective fantasy there is an interpersonal interaction by means of which the recipient is pursued to think, feel, and behave in a manner congruent with the ejected feelings and the self- and object-representations embodied in the projective fantasy. (p. 2)

Therefore, projective identification involves a series of subjective and intersubjective processes whereby the subject discharges or evacuates various unwanted attributes of self into the subjectivity of the analyst with the intention of manipulating the other to act in desirable circumscribed ways.

It should be clear from this model that projective identification is a form of unconscious communication (or more accurately, a series of metacommunications) directed toward the unconscious receptor of the analyst. At this point, it becomes important to question the degree to which an unconscious communication of this sort is possible, if at all. What is the epistemological criterion for determining whether a projective identification is indeed coming from the patient and is not merely the constructed fantasies of an overly imaginative analyst? Is the patient really capable of taking something (quite literally) from within his unconscious mind, and then transmitting and placing it into the mind of the therapist? Is there really some form of isomorphism transpiring between two subjectivities? Or are we merely treading into the realm of speculative, creative fantasy as a means of tolerating clinical phenomena that are not so easy to comprehend or constrain? Is conceiving of projective identification in this manner not a means of superimposing some form of order on that which we experience as beyond our control? Is countertransference a reliable touchstone for understanding the unconscious life of the patient? Is projective identification capable of inducing such countertransference enactments? Does this speak to the patient's projected internal world or does it tell us more about the therapist's? These are indeed difficult questions

to answer, all of which hinge on the defensibility of epistemological justification. Perhaps we have no other recourse than to rely on the bona fide associations from patients and the use of introspection and self-analysis from the therapist in order to broach the possible verity of these solutions. Perhaps we may only use the analytic process as our guide, thus open to interpersonal negotiation if not an amenable critique (and possible consensus) of the objective dimensions of external reality (e.g., what was actually said, invoked, enacted, etc.), concomitant with the discursive intersection of competing experiential subjectivities that inform the therapeutic dyad.

I take as a presupposition that unconscious communication transpires, and is evinced in a number of normative psychic operations, behavioral observations, physiological arousal levels, and clinical situations, much of which are open to empirical investigation and critique. Despite the fact that the concept of unconscious communication has been espoused since the early days of psychoanalysis, nowhere do we see such a preoccupation with this subject matter than in the much underrecognized and underappreciated work of Robert Langs, who founded the strong-adaptive approach of communicative psychoanalysis (see Langs, 1992, 1993; Smith, 1991, 1998). Langs has devoted his entire professional career to studying the processes by which encoded perceptions and unconscious fantasies are communicated on manifest and disguised levels of associational interactions that are often consciously unrecognized and unacknowledged by both the patient and therapist at the time they arise. While it is beyond the scope of this immediate context to explore these ideas fully, Langs cogently argues for the empirical verification of unconscious communication. If unconscious communication were not possible, then we would not emotively react to others so strongly: They would merely be filtered through our perceptual apparatus just as any other piece of objective data would be experienced in consciousness and hence processed, assimilated, then stored as information. The mere fact that others arouse in us intense and unremitting ruptures of internal protest, dread, anxiety, conflict, and the like point toward an intersubjective, dialectical tension arc of mutually inflicted and reciprocal unconscious interactions.

The dynamics of projective identification as unconscious communication and its implications for acknowledging countertransference can be grasped once the therapist becomes aware of the specific experiential states that are being induced in him during clinical exchange. In countertransference, we normally act on impulses or emotional reactions (based upon the peculiar contingencies of our psychic registers) rather than realizing in the moment that they are being cajoled, exhorted, or goaded on by the patient as a particular form of manipulative wish-fulfillment. Moreover, the reason why we often react rather than act is because we experience the projective identification as an exploitive intrusion on our psychic constitution. Despite being able to differentiate self from other, the knee-jerk reaction is to unwillingly absorb the patient's alien projection as an ego-dystonic identification because we feel it so forcefully—to the point that it becomes confusing to discern the place of its origin—hence the term "projective identification." Because we are epistemologically more aware of our own immediate internal experiences than tracking the process of inducement, it is no wonder why projective identifications trigger strong countertransference reactions.

Cashdan (1988) argues that in projective identification, the patient unconsciously enlists the therapist to experience the feelings associated with the patient's disowned internal dramas, and then pressures the therapist to act on such fantasies and behave accordingly—such as to become submissive (a projective identification of dependency), dominating or hostile (a projective identification of power), sexually aroused (a projective identification of sexuality), and obsequious or self-sacrificing (a projective identification of ingratiation). Cashdon shows that these four major forms of projective identification can be used to understand the relational stance and the induction the therapist is being enlisted to participate in:

1. A projective identification of *dependency* elicits a relational stance of *helplessness*, whereby the unconscious communication is "I can't survive," thus inducing feelings of *caretaking* in the therapist.
2. A projective identification of *power* elicits a relational stance

of *control*, whereby the unconscious communication is "You can't survive," thus inducing feelings of *incompetence* in the therapist.

3. A projective identification of *sex* elicits a relational stance of *eroticism*, whereby the unconscious communication is "I'll make you sexually whole," thus inducing feelings of *arousal* in the therapist.
4. A projective identification of *ingratiation* elicits a relational stance of *self-sacrifice*, whereby the unconscious communication is "You owe me," thus inducing feelings of *gratitude* or appreciation in the therapist.

Projective identifications are often attempts to repair, undo, or mitigate serious levels of psychopathology in the self. Fortunately, the internalized osmotic representations and behavioral fantasies of the patient as introjective identifications can be transmuted once the clinician becomes rudimentarily aware of them as such. The realization of being drawn into a projective identification can be turned into an empathic tool in order to make or reestablish a connection to the patient. Tansey and Burke (1989) point out how the patient's use of projective identification may stir up in the analyst similar experiential self-states that mirror or complement the immediate experience of the patient. When the therapist becomes aware of a temporarily heightened internal emotive experience that is qualitatively different from more usual or neutral experiential self-states while in interaction with the patient, then one may suspect that a projective identification is in play. When I am led to believe that I am being seduced by the patient's projective identification, I use this as an avenue for speculation and hypothesis testing about the therapeutic situation. Once I become aware of my own internal emotive (countertransferential) states, I pose the hypothesized question in my mind of whether the patient is experiencing something similar to what I am experiencing (viz,. modifying Racker's notion of complementary or concordant identifications), and hence what this may potentially tell me about the patient's inner reality as well as the relational climate between us. So for example, if I notice an immediate surge of annoyance or repudiation of what the patient is associating about, I wonder if the patient may be

experiencing similar emotional states about me or others (that have been displaced onto me), which have not yet been directly addressed between the two of us. This process many times than not affords me a more harmonious understanding of the patient's immediate subjective experience, which aids me in making desirable empathic, responsive, and validating connections in the here and now of therapeutic dialogue. Beres and Arlow (1974) nicely conclude that:

> The affect which the therapist experiences may correspond precisely to the mood which the patient has sought to stimulate in him. . . . Empathy in such instances consists of recognizing that this is precisely what the patient wishes to provoke in the analyst. The affect experienced is a signal affect alerting the therapist to the patient's motivation and fantasy. If the therapist does not recognize this, then empathy has failed and countertransference takes over. (p. 35)

Because characterologically disordered populations often have discontiguous and incongruent emotional-processing capacities, projective identification becomes a primary method of regulating psychic structure and disruptive inner self-states. A key technical principle in turning a potential countertransference rift into a bridge for empathy is being sensitive to signal affect and abrupt shifts in experiential self-states in order to reverse the impulse toward malignant countertransference reactivity to affective attunement and facilitative identifications necessary to make empathic linkages.

DEFUSING BORDERLINE RAGE: FROM PROJECTIVE IDENTIFICATION TO EMPATHY

The following case study is based on a two-year, biweekly treatment of an attachment-disordered patient whose personality was organized around repeated developmental trauma from family members through ongoing verbal devaluation, interpersonal rejection, and emotional debasement, thereby leaving a highly entrenched aggressive self-structure. This patient stands out, more so than others, as one of the most viciously hostile and verbally assaultive borderlines I have ever encountered in my practice. The aim of this section is to explicitly address technical consider-

ations for defusing destructive rage in the immediacy of the clinical encounter by closely examining an intervention segment taken from a taped-recorded therapy session. I have specifically selected this particular session because of how I attempted to transform my own countertransference reactions in the moment through empathic linkages to the patient's emotional pain.

Cheryl was a 36-year-old female of Ukranian descent when I first began treating her through a university counseling center where I was employed. She was divorced from a man twelve years her senior who was a professor at a prestigious university, but she was recently remarried to a school teacher and accomplished jazz musician. She was a nontraditional, full-time student majoring in psychology at the time she entered therapy under the mandatory directive of the Dean for cursing out a professor in class. Apparently the patient initiated an argument with the instructor in a course on feminine psychology that escalated into a heated debate: Unable to retain her composure, she told the professor to "Fuck off."

When I first met Cheryl I thought she was manic. She was talking a mile a minute with pressured speech, rapidly shifting from topic to topic, and I was barely able to follow her train of thought. She preferred to pace the room and gesticulate with her hands while she recounted her recent preoccupations and biographic narratives. I preliminarily assessed her current mood, affect, and behavioral symptomology and thought that she may have had an undiagnosed bipolar disorder. She told me that had been depressed several times in her life and that she used large amounts of cannabis on a daily basis as a means of calming her mind, which she reported was always racing with multiple thoughts. Expressing my concern, I asked if she would mind seeing a psychiatrist to determine if medication might help with her symptoms. At the end of our initial meeting, she expressed interest in seeing me on a weekly basis at my suggestion and accepted a referral to the clinic for a consultation with the psychiatrist.

During our second session, Cheryl told me that she had gone to see a physician at the clinic but claimed that he was an "asshole" and left during the intake consult because he was not listening to her. Her character pathology soon became more ap-

parent as she described a history of intense and conflictual interpersonal relationships with men, always ending in volatile and acrimonious ways, ambivalent relations with women, ambiguity over her identity and what she ultimately wanted to do as a career or pursue in her life, a lifelong addiction to marijuana, rage as a primary emotion, and a very angry-preoccupied fixation with multiple developmental traumas she incurred from her family. Her borderline personality was organized around structurally aggressive self-states primarily in response to how she felt emotionally abused and invalidated from her father and older brothers while her silent and detached mother passively observed and never bothered to come to her defense. Yet, fortuitously, she felt she was married to "the best man in the world," whom she described as a loving soulmate she cherished.

Cheryl immediately took a liking to me, and an idealized transference arose within a couple of months. I was described as a "wonderful" therapist who understood her and acknowledged her pain unlike her family members, and my personality was described as "warm" and "accepting," unlike her previous therapist, with whom she could not feel comfortable or open. The first year of treatment largely consisted of forming a positive working alliance where I adopted the therapeutic role of an empathic and mirroring selfobject by validating her past deprivations and emotional hardships with her family of origin as well as recognizing her unique talents and potential. The transferential symmetry with her husband Jonathan was quite apparent as I was raised to a pedestal just below his level of import and stature.

During this stage in the therapy, the patient had delved into much genetic material and realized that her first marriage was to a man—she identified him as a bipolar alcoholic—who was a surrogate of her father, a first-generation immigrant who became a physically disabled, emotionally combustible, degenerated alcoholic. Feeling dislocated from his own country and having to learn a new language, her father was forced to enter into manual labor and injured his back. As a result, he took out his rage over his lack of professional and financial success on his family. Because he had acted out and displaced all his frustrations on his children, especially his sons, the systemic anxiety,

hate, and bitterness trickled down to Cheryl, for she was the youngest child who was perceived as the most helpless and vulnerable member of the family others could disparage and control. Her mother was identified as an unavailable depressive who simply accepted her fate in life, and had little energy to combat the climate of lability and misogyny that defined the family unit. The patient's addiction to "pot" was a means of self-medication to cope with the affective aftermath of growing up in an "emotional concentration camp." Her husband Jonathan was identified as being her salvation from a life of misery.

The patient was so motivated to examine her dynamic past and its effect on her personality that we increased the frequency of our sessions to twice a week, which continued until the end of the academic year. At this time, I had accepted a new job at a mental health clinic of a general hospital in the same city and would assume my new position in midsummer. The patient agreed to continue her treatment with me there once she returned from her summer vacation with her husband. Because he was a teacher and she was a student, they planned to take the summer off to do some traveling and visit his family in the midwestern United States. We agreed that she would call me to arrange an appointment when she returned from her holidays.

Once settled into my new position, the summer soon passed into early fall but I had still not heard from my patient. Since we ended things on a good note, I assumed that she felt her life was going well and found it either unnecessary to return to therapy or difficult to continue for some reason that may have been related to her improvements or perhaps the idealized transference. Then one day I received a page on the unit only to find Cheryl on the other end of the phone in a state of suicidal desperation. I asked her to take a cab to the clinic, where I soon met her. Cheryl was visibly upset and hysterical, claiming that Jonathan was a chronic drunk who had recently battered her, and now she was seeking a divorce. Because the events had just transpired a few days beforehand, she was devastated, overwhelmed, and feeling suicidal. Astonished by the turn of events, I attempted to ground her emotionally and shore up her functional defenses so she could begin to recover her faculties. After two hours of crisis intervention, Cheryl was feeling much calmer

and in control. Feeling reasonably sure she was now feeling safe and would not engage in self-harm, I informed her that I had another scheduled patient I needed to see and wished to see her the following day to resume our therapy so we could process and work through the unanticipated trauma. But as I attempted to end the session for the day, Cheryl claimed she was suicidal and could not promise me that she would refrain from attempting to kill herself. After performing another suicide-risk assessment, I determined that she needed to see the psychiatric resident on call in order to be hospitalized. But as soon as the psychiatrist arrived, to my chagrin Cheryl denied feeling suicidal at all. Feeling quite embarrassed, I thanked the doctor for his attention and told him that I would handle things from hereon. Yet as soon as he left and I pushed to end the session, she claimed again to be suicidal. Annoyed yet composed, I told her that if she continued to manipulate me in such a fashion we would not be able to work with one another any longer. I acknowledged her pain and desperation, but I equally needed to institute a firm frame delineating the boundaries of treatment. Because of our positive work together and her (albeit tenuous) attachment to me, this intervention was successful, but the parameters of therapy were never to be the same.

We resumed our biweekly schedule, but in a stormy fashion. She was enraged with me for ending the crisis session and not making her a priority over my other patients. My once-coveted idealized presence rapidly devolved into a detested and worthless obstacle to her happiness. Torn from the pedestal, I was reduced to rubbish and seen as a cold, unavailable, invalidating, and withholding dependency figure not unlike Jonathan or her family members. No longer the apotheosis of warmth and concern, I, like Jonathan, was intrapsychically recasted through a prolonged devaluation period. The transference not only became negative, it was toxic and nihilistic. For months I became of the object of intense hate, disparagement, and ridicule. She treated me in the abusive ways she herself was treated by the significant figures from her past, yet this time the shoe was on the other foot. Her constant barrage of criticism, deprecation, and unremitting verbal maltreatment seemed unconsciously designed to seek revenge, through her displaced discord onto me,

toward all those who had wronged her. The weeks of being assigned the role of the emotional whipping-boy took a toll on me and mobilized intense countertransference feelings of rage, hate, helplessness, and inadequacy—as well as revenge fantasies of my own that I wanted to act out. I loathed getting up in the morning and going to work on days that I had to see Cheryl, knowing only so well that I would be verbally accosted as the bad object and recipient of her projected abhorrence and destruction. At times, the containment of affect (hers and mine) was so difficult, I literally would be riding out the chair (white knuckles and all) as though I was being plummeted into the eye of a hurricane, writhing the whole way. Verbal tirades and yelling monologues were common, and one time she was screaming at me so loudly that two staff members opened the door to my office fearing that someone was being beaten.

The following section comes from a taped recording of one of our sessions, approximately a year and a half into the treatment. This episode depicts the heart of the devaluation period characterized by extreme splitting, omnipotent evacuation, and projective identification. I chose this particular interchange because it illustrates how I was drawn into a countertransference enactment under the pressure of feeling threatened, persecuted, and assailed—a possible scenario I believe any clinician can potentially identify with; yet I feel I was able to recover from the assault within a timely enough manner to respond in a more optimal therapeutic fashion. This section begins with volatility as I suggest the value of examining interpersonal connections between her current hostility toward me and conflicts with others she repeatedly encounters outside of therapy. In order not to the disrupt the natural flow of the dialogue, which is punctuated by the patient's loud voice accentuated by her intense and explosive affect, I will present the exchange in unedited form and then offer my analysis of the intervention.

THERAPIST: Cheryl, understanding what's going on between us will help you understand what's going on and feel better about your life in general.

PATIENT: No! How about when I come in and I was loving and good and responded to you? You still didn't do any good, so

what's the difference? It wasn't manipulation.[4] It was like, you know, like the parts of me that are healthy, that are happy, that connect, that are very intellectual, that are very intuitive, that are very sharp, multi-eclectic, able to deal with people on different psychological levels—No! I don't feel I'm backed up by you.

THERAPIST: You don't feel I've appreciated that in you?

PATIENT: *No!* Not at all! You've never said it, how would I know? I can't read minds. How the fuck would I know?

THERAPIST: Because I recall several times saying . . .

PATIENT: Yeah, but it's so low, and it's such a pip-squeak voice, it has no strength to it.

THERAPIST: So it must mean that I don't believe it?

PATIENT: Right.

THERAPIST: It must mean . . .

PATIENT: It's weak, ineffectual, half-assed, half-meaty. I've got to bully it out of you cause you couldn't just give me something naturally like you promised to give me, so naturally I'm *bullying* it out of you—*aggressing* it out of you!—instead of it being something loving and nice, like I go to reach out to people. [*a moment of silence*]

THERAPIST: Cheryl, there's so many parallels between you and your relationship with Jonathan and with me . . .

PATIENT: *No* there isn't! Because you weren't there when I did all the loving good things. And you won't read the evidence about what a good woman I was through it. You're goin' to try to switch it like I demanded and pressured Jonathan beyond—yeah maybe I wanted Jonathan to love me like the way I wanted him to love me, but it was the way he had professed. And when I'm dealing with—I was dealing with lies and broken promises, and fucking intimacy distancing, and fucking drunken asshole, selfish jag-off behavior! That was fucking Jonathan's fault. It doesn't matter who the fuck he was with—let's get that straight right now. Now we can go into blaming me for whatever you want to blame me for, but that's Jonathan's shit, period. Jonathan had

his shit long before me, and that's why I've tried to show you evidence of how he treated others or who came before me, or his journals. But that's his shit—okay. He was onto something loving, honest, and good. What's really funny is when I'm not abused, like when I was with the Redpath's, I'm able to heal, I'm less angry, I'm treated better, because there's a little support or validation there, which is the normal fucking support that every human being needs as according to Maslow—okay, just normal shit. When I get normal shit without people criticizing me, judging me, or throwing their shit on me—and Jonathan was trying to make me codependent—that's the shit that was going on, that's the dynamic. And my esteem was fighting that crap. I wasn't goin' be another person so I could have my husband whomp me—that was the fucking dynamic.

THERAPIST: I guess because I don't always comment and respond and verify what you say that you do feel that I'm not on your side, that I must think that it's your fault, you're to blame, and I want to throw things right back onto . . .

PATIENT: Absolutely! [*breaks down sobbing*]

In the initial part of this segment, the patient was complaining that I was not available to her as a responsive and validating agent in the way that she wanted nor needed for me to be, and therefore she interpreted my comments and actual presence as frustrating, withholding, and depriving. Initially I tried to appeal to the healthy part of her ego by introducing some reality testing around the fact that I had on several occasions in the past demonstrated my support and appreciation of her, but no sooner than I began to call her attention to this, it was met with a steadfast disavowal of its importance and sincerity. Unable to acknowledge my previous treatment toward her due to her splitting and affective coloration, she continued to disparage my past supportive comments toward her as being vapid, hence lacking vigor or conviction, which was now tainted by her disappointment, condemnation, and rage for not giving her what she felt entitled to in that instant. She then projected her fantasy that I had "promised" to give her some form of unconditional acceptance, which was probably fueled by the previous idealized trans-

ference, but now was contaminated by my perceived withholding comportment, which only mobilized more rage as she continued to intimidate and "bully" me into providing her the selfobject functions she so demandingly craved.

By this time, I was feeling sufficiently attacked and under the influence of my own countertransference, which I enacted through a transference interpretation. Tracking my own defenses over the years, I recognize that I will sometimes resort to premature interpretations as a way to diffuse my own anxiety related to tensions in the clinical moment. But my transference interpretation, while perhaps accurate, fell flat, and only provoked more negation, rage, and effusive indignation. With the further onslaught from her devaluations and need to destroy me for my transgressions and empathic failures, her emotional diatribe slowly precipitated my awareness that I was responding to her projective identification. In other words, I became self-conscious enough in the exchange to realize that I was identifying with the projected attributes and behavioral fantasies she was evacuating into me. Although I was feeling besieged, defensive, and emotionally pummeled, I could recognize that this was how she was experiencing me in that moment: like Jonathan and her family, I was ganging up on her, negating her—aggressing against her to the point that she needed to attack me in order to combat the affect dysregulation and dread associated with the negative introjects and internal objects imperiling her psychic integrity. It is here that I was able to use my countertransference to her projective identification (viz., through vicarious introspection) by acknowledging her affective pain about feeling invalidated, blamed, and rejected by me. By recovering my therapeutic leverage through empathic attunement to her perception of my unavailability and lack of recognition and support, I was able to diffuse her rage in the emotional clash of our intersecting subjectivities, which then allowed us to explore throughout the remainder of the session how this felt like a reenactment and recapitulation of her whole volatile interpersonal history with her family.

Throughout the course of this tempestuous period in therapy, Cheryl was able to see her repetition of setting up interpersonal relationships to fail by orchestrating conflict and hence bringing about the very thing she did not want to happen: in the

end, people distance, repudiate, devalue, and ultimately reject her. When Jonathan hit her—only to end their relationship—she was transported back to her first divorce (which ended bitterly) and ultimately to feeling abused by her father, forsaken by her mother, and ganged up on by her brothers. Like so many borderlines with aggressive self-structures, the immanent threat of her encroaching abandonment depression signaled rage that was mobilized as a self-preservative defense to ward off disabling depletion, concomitant with an impulse derived from a deep narcissistic injury to destroy the bad object who had transgressed and aggressed upon her self-integrity. Jonathan went from idealized Prince to detested batterer, which paralleled the negative transference and radical splitting that transpired in the treatment.

There was a malignant narcissism to Cheryl's need to avenge her damaged self. It turned out that during the alleged beating from her husband, the patient initiated physical aggression toward Jonathan during a mutually drunken stupor, whereby he slapped her in return. After he made it perfectly clear that he did not want anything to do with her again, she wanted to vindictively hurt and deeply humiliate him for his callous rejection. Apparently the couple had leased a new apartment for the fall and put their belongings into storage before traveling for the summer in order to save expenses on rent. Because the altercation and subsequent breakup of the relationship took place while visiting his family, she returned to the city without him. Upon arriving home, she immediately opened the storage unit that they had rented and sold many of his personal belongings to pawn shops, among which were several vintage guitars for which she received only a fraction of what they were worth. After this, she stood on a busy sidewalk corner and gave away crates of his jazz albums to strangers who were passing by on the street. Furthermore, she sent a letter to Jonathan's place of employment stating he was an abusive alcoholic and should be fired for moral turpitude, then wrote another letter to the Internal Revenue Service charging Jonathan with income tax evasion and fraud by failing to claim his extra earnings from his weekend music gigs. If this was not enough, she stalked him outside his new apartment and threw a brick through his car window, result-

ing in having a peace bond placed on her under an order of protection.

After we sufficiently worked through this stormy period in therapy, I was reinstated as a supportive and validating selfobject but in a less (hence more healthy) idealized light. Cheryl was more capable of seeing me (albeit imperfectly) in a more integrative and holistic fashion as someone who was fallible yet well-intentioned, with both positive and negative qualitites. In essence, she "forgave" me for my limitations and was more able to bear frustrations she once found simply intolerable.

Our work together was unavoidably and prematurely ended because I had accepted another job that required me to move to another city. We had approximately three months of dealing with our termination that predictably brought up old wounds around rejection, abandonment, loss, and emptiness surrounding failed relationships and her lack of receiving parental love. An erotic transference began to emerge during our termination period, which rekindled old patterns of acting-out. She began hanging out at nightclubs, doing heavy drugs, was sexually promiscuous, and engaged in risky behavior such as riding the subway late at night in dangerous parts of the city. As a turning point, what was a most fortunate denouement was that she was eventually able to acknowledge that she was acting so desperately as a means of warding off the depletion associated with mourning my loss. This shift allowed us to return to looking at our relationship and the positive feelings she had experienced from my valued presence and responsiveness. The treatment ended with mutual recognition of each other, and Cheryl surprised me with a gift that had certain personal significance to her, namely, a small decorative harp that symbolized the therapy that allowed her "soul to sing."

I consider my treatment of this case to be both successful (within the limited context of the established therapeutic milieu) yet ultimately delinquent, for it failed to produce the type of structural shifts that only long-term intensive analytic treatment could bring about. At the time, Cheryl rejected the idea of being referred to another therapist to continue with the work that we had initiated, instead wanting to preserve the positive ambiance we had eventually achieved together. Years later I was told by

my old boss that the patient had called the clinic and demanded to know my exact whereabouts in order to contact me, only to verbally threaten the director when she did not release such information. While this points to the unabated aggressivity that saturates her psychic structure, it may also suggest that I was at least partially internalized as a positive presence within her representational world.

TRANSMUTING COUNTERTRANSFERENCE

Because countertransference is a relational phenomena and not merely an intrapsychic one, it becomes reasonable to hypothesize that when the clinician notices countertransferential experiences within his own subjectivity, strong emotional ruptures are equally being mobilized and unconsciously transmitted by the patient as well, thus informing the intersubjective field. It is more often than not that a patient's experience of me unconsciously mirrors my own experience which I have either assimilated and/or defended against as a form of projective identification from the patient's unconscious and preconscious communications.

Countertransferences are communications about the paucity of affective and relational involvement the therapist has with the patient. Since strategies for managing countertransference potentially apply equally to all clinical populations, the first task is to become aware of it. But how do we know when we are embroiled in a countertransference if by definition countertransference is unconsciously motivated? Perhaps it is more conscious than we may want to admit. In addition to noticing the sundry possibilities of countertransference described earlier, we may also notice changes in our patients, such as coming late to sessions, late cancellations, remaining silent, or acting different in sessions than their customary mannerism conveys. When we are enmeshed in countertransference, we often have myopia or tunnel vision because our self-reflective capacities have been overshadowed by forceful emotional pressures that do not afford us the critical distance we need in order to see more vividly the multiple, parallel processes that are simultaneously operative. The lazy therapist who does not think about his patients outside

of the consulting room is more prone than others to ruin the treatment or perpetuate bad therapy.

Detection and recognition of certain signal experiences is the first step, and, as mentioned earlier, signal affect is often a good touchstone to alert the therapist that something is happening. When clinicians begin to focus their self-consciousness on the unearthing of such signal experiences, it should be an indication to step back, reflect, and examine the process transpiring within one's own subjectivity *and* the intersubjective field. When certain disruption threats are noticed, such as ruminating about the patient, focusing on narcissistic injuries, assaults, rage, and so on, there is a danger situation brewing, and like Freud's notion of signal anxiety, the ego is alerted to peril. In these situations, one's self-image is torn or flooded with feelings of rejection and ineffectiveness, thus mobilizing retaliatory impulses to dump back onto the patient or to block out from awareness the emotional significance of the onslaught inflicted on you as therapist. Under these circumstances, Lubin (personal communication, 1990) advises us to examine the good and bad self-representations of the therapist *qua* therapist that are evoked in such a dynamic polarity, and entertain a process of internal release and elaboration of the fantasies mobilized within. This potentially allows for a discharge of internal frustrations that are controlled and confined to a safe atmosphere characterized by self-acceptance and internal transmutation.

Allowing one's internal fantasies a contained and sublimated outlet for expression affords a more harmonious self-experience, without having to suppress or avoid discomfort, which furthermore becomes an impetus for the therapist to shift into a different psychic field with affective utility. Rather than renouncing or blocking disruptive countertransference experiences, one should sustain such internal activity in order to see it through to some therapeutic end within the countertransference and within the analytic dyad. Silently welcome your countertransference rather than repudiate it: If you do not get through the initial shock and intrusion, then you will not fully understand it or transform it into more productive catalysts for change.

As a general rule, it is best to curb or inhibit your initial reaction to act so you may sit back and reflect on the impulses

and affectivity that are triggered within, thus allowing for linkages and parallel associations to surface and to be processed. Despite the press to react, if you delay you may gather your sensibilities and potentially realize the myriad parallel processes that are operative. Think about the precipitating events that triggered your reactions, and relate them to your own developmental contingencies, life history, and the broader frame of the established therapeutic context.

Once you have come to notice the experiential shifts in your own self-states and the associative connections to your inner subjective world, it becomes essential to think of this as an opportunity to form an empathic link to the patient's inner experiential habitat. How do you empathize with someone who repulses you? How can you feel a connection with a patient whose behavior is so appalling, disruptive, or aversive that you wish you would never see him again? These strong affective reactions communicate to us that we are intimately conjoined to our archaic past. What kind of intensive identification is unearthed when we have such affective coloration in the moment? When this happens, we are transported back to certain life or childhood experiences in our developmental histories that still live within our deep interior. These trigger events stoke the unconscious stove of emotional resonance states that we find most incomprehensible and horrific. But they can be harnessed as an ally toward broaching an intimate and empathic connection to the patient once they have been corralled and brought into self-reflective containment.

Countertransference obliges us to open ourselves up to our own childhood fears and anxieties that are in response to, parallel, or mirror the therapist's present experience of the patient. When focusing on shifts in self-states or induced emotive countertransferential reactions, ask yourself: When would *I* have acted like the patient is acting? When would I feel that way? Put yourself in the patient's shoes in order to recall a previous time in your life when you may have felt or behaved in such a fashion as the patient, or at least begin to imagine what events would bring you to experience such a similar lived encounter, such as during conditions of extreme frustration and pain. For example, if you feel devalued by the patient, then think to a prior point when you may have been perceived to have devalued him. Re-

gardless of what your internal shift, signal experience, or emotional reverberation is about, the patient is transmitting a certain unconscious trajectory of unarticulated or unformulated experience by making you feel the way you have made him feel, and as a result, he is communicating to you via projective identification such experience. Use this as a guide or orienting principle toward speculation and further investigation. If you are able to do this then you will move past the projective identification and transform the initial countertransference reaction into a more appropriate empathic attunement with the patient's projected self-states, which then affords you distance from your emotional reactivity in order to provide containment and understanding. This is similar to what Bion (1962) had in mind when he spoke of *reverie*—namely, the adaptive accommodation and transmuting metabolization of projective identification given back as empathic responsiveness and interpretive insight.

The nature of when the therapist should or should not disclose or openly interpret the countertransference cannot be considered here. Much of this depends upon the unique contingencies of the therapeutic moment, the conditions and purpose such communications would serve, the affective climate, the motivations and conflicts operative within the analyst and the patient at the time, the capability of the therapist to have attained necessary critical distance versus acting-out, the anticipated receptiveness of the patient, and, of course, the hypothesized subsequent impact on the therapeutic relationship such countertransference disclosures would likely produce. There is no pat formula one can apply because each intersubjective context is different. The therapist must learn to navigate through the analytic process as it unfolds in the lived experiential moment, a skill that is always transmuting and open to refinement.

NOTES

1. The term "analytic instrument" is an unfortunate one because it evokes a mechanistic, antiseptic technical metaphor akin to a medical procedure, when Lasky arguably had in mind the signification of the analyst's professional, clinical sensibility informed by his entire subjective agency.
2. The term "transcendence" has a long history of meanings in theology and philosophy. It often implies overcoming or surpassing something to the

point that one achieves a beatific, sublime, divine, or ineffable relation to the past. In this discussion I emphasize a more ordinary transcendence (in contrast, see Grotstein, 2000; Gargiulo, 2004) of sublating previous dynamics within a higher order of understanding as the comprehension of such previous dynamics, rather than the religious-spiritual definitions that are often associated with this word. Here, countertransference is never totally dissolved or left behind, but rather incorporated into higher organizations of meaning and personal-intersubjective awareness.

3. In *The Ontology of Prejudice* (Mills & Polanowski, 1997), I argue that human subjectivity is ontologically conditioned to be prejudiced a priori by virtue of the fact that consciousness is the elemental expression of value preferences and judgments that are necessarily self-referential. Prejudice is a universal expression of our narcissistic facticity with positive and negative valences derived from the unconscious disclosure and expression of value preferences. Preference is prejudicial for it signifies discriminatory value judgments that are self-referential and typifies the priority of determinate valuation. Because valuation is a particular form of self-expression, and all judgments are imbued with value, valuation is prejudicial because it stands in relation to our self-preferences. Therefore, all judgments presuppose self-valuation that are by definition prejudicial. This is why at bottom, every human being by nature is prejudiced: only the degree and forms of prejudice vary from person to person.
4. In "Negation," Freud (1925) tells us how spontaneous denial (*Verneinung*) is often in the service of repression.

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1104 Shoal Point Road South
Ajax, Ontario L1S 1E2
Canada
E-mail: jmills@processpsychology.com

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