

## **AUTHENTICITY AND ITS COUNTERTRANSFERENTIAL VICISSITUDES**

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In my paper, I would like to consider some aspects of an analyst's mind at work, when the analyst struggles with his own emotional state being affected by a patient's projection. Results of this internal work vary and depend on many factors that rest both in the patient and the analyst.

Freud (1937) in one of his last texts, *Analysis Terminable and Interminable*, questioned effectiveness of psychoanalysis. He worded his worrisome conclusion, probably somewhat tongue-in-cheek, calling psychoanalysis an 'impossible profession' which 'one can be sure beforehand of unsatisfying results'. Freud seemed to notice excessive narcissism of analysts when they were convinced that intellectual understanding was enough to change a patient (Brenman, 2006). Yet, in his earlier papers, Freud, apparently, viewed the analytic ideal to be self-control, referring to it figuratively as the 'mirror', 'surgeon' or 'blank screen'. The non-alignment attitude was preferred as emotional reactions to a patient were considered a professional failure and evoked guilt. At the beginning of the 1950s new ideas emerged and the development of the countertransference concept was the breakthrough in the analytic technique. Thanks to brave speeches of Heimann (1950), but also Racker (1953) and others, the analysis revived, getting a more vivid and more direct touch. Heimann pointed out that countertransference could be a tool for understanding the patient's unconsciousness. That concept included an analyst himself in the analytic process, with his personality, emotional potential to work through a patient's projections, but also his personal limitations. The analyst's understanding or not understanding was related to the patient and his influence on the analyst as well as the analyst's response to that impact.

In agreement with the work of Bion (1962), Rosenfeld (1987) and Brenman-Pick (1985, 2012), I believe that a patient seeks an object in us who could contain, understand and thus, transform what he himself cannot experience and/or think. It poses a challenge for our both readiness to feel disrupted in result of the patient's projection and for working through our own emotional states, which is fundamental to understanding the patient.

Patients find their ways to 'tap on' various emotional states in the analyst. A specific type of countertransference the analyst responds with is dependent on a specifically directed

projection of the patient. It targets, as Brenman Pick (1985) points out, at a specific aspect of the analyst's mind, e.g. a desire to become a mother or to be omnipotent. More often, however, the projection is aimed at internal objects of the analyst, especially the superego. The patient's projections may disrupt the analyst, finding his personal inclination to react in a certain way. Furthermore, some patients can accurately sense the analyst's actual characteristics and choose them as grounds for their projections (Money-Kyrle 1956; Feldman 1997; Davids 2018).

Many authors, Brenman Pick (1985), Carpy (1989), Cassorla (2007) among others, strongly believe that the patient subconsciously perceives the analyst's emotional struggles which exist within their relationship. Furthermore, Carpy also states that inevitable subtle countertransference enactments allow the patient to see that the analyst, even if affected by his projection, does not give up and continues his attempts to understand. This process, according to the author, enables the patient to gradually reintroject previously unwanted aspects of himself. This is especially so when the analyst recognizes the enactment and tries to understand its meaning. Thus, he restores the function of symbolic thinking along with receptive, unfocused attention, which constitute the axis of the analytic function (Bion, 1962, Birkested-Breen, 2016, Segal, 2005, Steiner, 2016).

In my paper I would like to show that the analyst's ability to recognize not only what distinguishes him from the patient, but also what seems similar, constitutes a significant element in working through countertransference. The analyst, when receiving and containing patient's projections, must ask himself about his willingness (readiness) to feel and imagine some kind of similarity to the patient's internal object or/and the patient's feelings about the object. Undoubtedly, it requires courage to face one's own anxiety and uncertainty as, inevitably, it confronts the analyst with his personal limitations and preferences for a specific relationship with the object (Feldman 1997). If this willingness is to be understood as authenticity, it becomes a key aspect of receptivity and containing then, which facilitates the process of transforming the patient's projection and understanding. Thus, the analyst's authenticity, as considered by Brenman Pick (2012), is manifested in his readiness to explore his contribution to an analytic dyad. I think that lacking this readiness may lead to a defensive countertransference (Money-Kyrle 1956), impasse and false understanding. The

analyst's internal work, before his attempts to reach the patient through interpretation, creates an authentic, three-dimensional engagement with the patient then.

In my view authenticity together with receptivity, containing and transformation of the patient's projection is an analytic ideal, which the analyst strives for and can only approach. If this ideal remains an aspirational object, yet separate from the ego, it supports the analyst at working with the patient. However, under influence of disrupted emotional states of the analyst, resulting from transference-countertransference dynamics, internal relations between the analyst's ego and its ideal (the ego ideal), as well as narcissism (the ideal ego) and the analyst's superego undergo changes. If the changes are actually merely a symbolic equation, then the ideal loses its aspirational function and countertransferential enactments take place. A clinical vignette, I'm going to present, should illustrate three scenarios of countertransferential vicissitudes in these relations; the analyst's ego equates with the ideal, becoming narcissistically inaccessible to the patient; or the ego identifies with the superego, becoming critical of the patient, or reacts with depression and resignation due to a critical evaluation by his own superego, revealing a discrepancy between the ego and the ideal.

### **Clinical vignette**

Ms A, a middle-aged female, is a biologist. In her relationship with me, she was afraid of dependence and tried to guide me. When she said that she liked to lead her partner when dancing, I thought that something similar was actually occurring in our relationship. I felt as if I had been pulled into a dance with her, tossed to the left, to the right, a little dazed and passive. During the sessions I found thoughts and feelings of Ms A difficult to grasp; they changed quickly and reversed their meaning. The patient herself called them 'jumping', here, there, and everywhere. I felt confused then and my unsuccessful attempts to follow and catch up with the patient frustrated me.

Difficulties in tolerating countertransference increased and thus the separateness of the ideal as the object of aspiration was becoming more and more elusive, weakening my symbolic thinking and blocking my working-through.

Occasionally, Ms A attempted to change the setting, wishing to reduce the frequency of her sessions or condense them. Nonetheless, she said once that the sessions were too short and leaving my consulting room felt like being kicked out. It turned out that after the sessions

she often sat in her car for many minutes, being emotionally agitated, unable to gather herself. Once, after a session, I saw through the window that she was sitting still on the curb of the street, holding her head in her hands. Sometime later, Ms A, when telling me about those emotional states, noted that she felt confused by feelings of rejection and by different thoughts about me. She emphasised she trusted men more and she associated the fact with her relationship with her late father, who, she felt, held her the dearest and most important. She felt his approval of her strongly, although she was disappointed by his alcohol drinking and temporary absences due to that. At one moment she could feel she had everything and flip into a deep abyss of having nothing at another. Her father died several years before she started her analysis. The patient described her mother as constantly criticizing her and being unreceptive of her feelings. She claimed that her mother's help usually turned into criticism, leading her to feel wounded and rejected. Ms A saw her relationship with her mother as a war and pointed out that she was becoming a warrior herself. It eventually turned out that Ms A had experienced postpartum trauma. Immediately after her birth, her mother became ill with sepsis. The baby was detached from the mother for two weeks. Ms A suspected that she was in an incubator for some time.

Recently, the patient (once) said she was considering either to terminate her analysis in two years' time (as her professional contract in the town where her analysis was taking place would expire) or to continue it, nevertheless. She stated that her analysis deprived her of spending more time with her husband and children. She pointed out that she often skipped attractive excursions or she missed sessions because of going away. Moreover, she said she had to deal with the feeling that I was dissatisfied when she missed sessions and she felt rejected by me in such situations. At the same time she claimed she would like to continue her analysis, however, she expected me as her analyst to act more casually when she misses sessions and not to think badly of her as it makes her feel guilty. In one breath she also warned me that in six months' time she would attend an attractive trip with her husband, children and friends.

I felt struck by the patient's laying the issue out so bluntly; I felt redundant and reduced to the role of someone who, possessed by analytic ideals, interfered with the patient's life. Although this aspect of the patient was known to me, nevertheless it appeared difficult to accept. That situation revived in me a memory of a last year event when the patient resigned

from one session. Ms A pressed on changing the setting and my attempts to discuss her motives and meanings of her pressure to give up one of her sessions proved futile.

I was 'dissatisfied with the patient' in my identification with my superego and I could not help my criticism, and then I felt guilty that I required too much from her and I wasn't receptive. After the patient's relinquishment of one session, I was left for a while with feelings of failure and resignation, which concealed my hostility towards the patient, as I see it today, even though I liked and valued her. In fact, my aversive reaction to the perceived failure was an expression of my difficulty in tolerating and working through feelings of helplessness and abandonment, intensively projected by the patient.

My experiencing of drifting away from the ideal of receptivity and working through the countertransference, I suppose, stroked my critical superego, which at that time turned against me. It resulted in discouragement and a sense of powerlessness. And now those feelings revived in me and I realised our clash hadn't been worked through properly and analysis was not going well. Also now the way the patient presented the matter made my mind inflamed with helpless rage and eagerness to treat Ms A accusingly.

After the sessions I felt that this state impeded my considerations over the meaning of how the patient referred to me. One could say that I gained a sense of my enactment reaction from the superego, and hence the loss of the analytic ideal as the object of aspiration, however, that process was not free from manic defences. For example, to my own surprise, I responded by making a comment to look for a solution that would accommodate both the session and the planned excursion. Thus, it seems that I sought refuge from my harsh accusations of the patient in manic denial of the actually prevailing struggle and pressure and in adjusting to Ms A's wishes. Perhaps that collusion was to provide me with narcissistic comfort; to protect me from a mutual disapproval, avert the feeling of failure and alleviate the narcissistic resentment.

However, it repressed emotions only for a while. Later in the same session, as I was struggling with disruptive emotions, the patient said her mother disapproved of her activities outside their relationship, e.g. the mother was highly critical of A's analysis, her travelling or her job. At that moment I lost my breath and felt stuck. I perceived those words as another form of pressure, i.e. A perceived me as a bad mother and suggested that it would have been therapeutic if I had approved of her missing sessions and acknowledged her life beyond the analysis. For the rest of the session I was overwhelmed by strong emotions, which I struggled

to control. However, I was far from being able to consider my own state and the significance of what was happening between us.

I think that my critical superego permeated my reaction in defence of experienced fear of losing my breath. I felt both my observing ego and supporting superego accompanied the process, pleased with my reserve and restrained reactions from the reaction. Due to the support of the ego ideal, I could tolerate tensions better and in subsequent sessions, as shown below, think critically and interpret. I could begin to regain the pursuit of the analytic ideal of receptivity, working-through and understanding.

The following session the patient started with a remark that her school-age son was reluctant about studying. A added she was annoyed with her son as he bargained with her and attempted to soften her attitude so that she would allow him to skip studying in favour of other activities. However, she claimed that her previous conversation with me about her son's problems allowed her to better understand her son and to attempt to refrain from forcing him to study.

I felt I captured the transference significance of that association. It seemed an unconscious reflection of the patient upon her interactions with me during the previous session when she had bargained with me so that I would refrain from forcing her to learn in analysis. Perhaps the patient sensed that I was working through my irritation with her for the way she treated me.

This time I was more confident, feeling that I had managed to attain an internal state that was relatively free from notes of indignation and condemnation on the one hand, and the desire to adjust to the patient for the sake of peace and quiet on the other. I interpreted that perhaps the patient would want me to come and stand by her side and understand that pressing her was not a good method to make her learn in analysis. After a moment, Ms A responded describing her horse-riding training, which, as defined by one of her trainers, relies on harmonising movements of a horse and a rider and finding the balance between holding and letting go. She emphasised that there was something genuine about that, just as there was in what we did in the analytic work. Ms A pointed out that the approach differed from methods applied by another trainer, with whom she was in conflict. She recalled a situation when she, sitting in her saddle, expressed her disapproval at his way of treating animals, when he was standing on the ground.

Initially, I felt being spoken down to and pressured to relent. After a moment, however, I began to think that maybe the patient did feel understood a little and it was her way of communicating that she found it somehow degrading when she was being pressed and forced instead of being understood.

The analytic ideal, I pursued, more often maintained its separateness and inaccessibility. I tolerated the countertransference better and made a use of it – I literally experienced feelings of being pressed and spoken down to in the relationship with the patient so that I could imagine how she felt. I also realised that in my identification with superego many a time I pressured the patient to be ideal. I was able to reflect upon similarities of my reactions to the internal, non-receptive, abandoning and critical object of the patient.

After a weekend break Ms A told me a dream where she saw someone drowning. She jumped into the water and saved a drowning baby, who emerged, gasping for breath. She associated it with her work with me; the baby was saved, but the antagonistic relationship with her equestrian trainer was beyond saving. I felt that gasping for breath was an experience I could relate to in last sessions and that it could be something significant for the patient.

Several sessions later Ms A stated she wanted to continue the analysis, but another part of her was conflicted. She added that at times she was immensely grateful for my patience, while at others times she felt that I was her worst enemy. She accused herself of being unyielding and was afraid it would recur. She claimed she did take notice of this aspect in her relationship with her husband, whom she often pressured and diminished, even though she tried to avoid it. Markedly 'softened', she went on to say that she feared submission and vulnerability, for this led to 'a bottomless abyss'.

The analysis commenced to be filled with infancy material, which posed a serious challenge to my ability to contain the patient's primitive, nameless fears and to maintain and recover the ideal as a separate object of aspiration. She often experienced anxiety and confusion, which later transformed into what she called 'immersion'. I wondered if this immersion was an expression of taking the risk of contact with something ineffable, unknown, terrifying or perhaps it was a form of control over me and a way of avoiding the recognition of the meaning of what was happening between us.

At that stage of her analysis, Ms A felt as if I was pulling her out of the incubator (or leaving her there). She besought me for pulling her out slowly. She blamed me for everything, just like she would her mother. She pointed out that she did not believe in my constancy and pressed me to immerse with her. It seemed to me she was pushing me to lose my head; other times I thought it was about unifying with her, so that I would feel and understand her drama.

I think that reality testing, i.e. differentiating between her experiences and feeling and mine, and using interpretations was difficult and painful, which she felt as if being pulled out of the incubator, her asylum, too violently.

### **Authenticity and its Countertransferential Scenarios**

The presented clinical vignette shows the analyst's struggle with painful feelings of diminishment and helplessness as well as his attempts to contain these emotions and consider their significance. However, this process is not always completed successfully. Frequently, a patient's projections disturb the relationship between the analyst's ego, ego ideal, and superego to a degree that precludes the use of the ego ideal. The analyst may then become narcissistic, overflowing with moral disapproval of the patient or filled with resignation and hopelessness. It is not difficult to imagine a process, where the pressure of the patient's projections can touch the analyst's narcissistic wound to such a degree that it causes painful feelings of powerlessness and failure. This coincides with a reaction of the critical superego, which monitors the analyst's pursuit of the ideal and rigorously evaluates the difference between the analyst's ideal and his perceived 'failure' to understand the patient. This negative assessment further aggravates a state which is already difficult to bear. This is the point when narcissistic omnipotence is sought, to protect oneself from the discomfort of offended self-esteem, feelings of failure, and the experience of not being loved by the superego (Dessuant 2007).

Thus, the relationship between transference and countertransference can take different faces and develop into scenarios stemming from the patient's directed projection and the analyst's personal susceptibility to react. They include both enactments and tolerance of countertransference. In the case of tolerated countertransference, despite the emotional pressure, the ideal is not lost as a separate object of aspiration. Both types of countertransference oscillate and intertwine with each other.

The first of these scenarios is based on the identification (equation) of the analyst's ego with the superego. The unbearable feeling of failure finds relief in "being superego" and blaming the patient for the lack of progress. This type of enactment results from uncontained and not understood projections of the patient that are directed toward the analyst's superego. Although this state of mind is dominated by feeling dissatisfied with the patient, it is in fact intertwined and 'fed' by discontent with oneself. It is a manifestation of the disrupted sense of separateness between the analyst's self and his object, as well as between his ego and the ideal, leading to equating the ego with the superego. Then, the analyst cannot help his criticism and thus recognise the significance of the patient's projection or link it to his own emotional state and make assumptions about what the countertransference may be communicating. Moral superiority and self-righteousness, which characterize (pathological) superego (Bion 1962), deprive the analyst of his receptivity. Quickly, the analyst 'returns' the projections of the patient along with his own material and seeks containment for his own helplessness, impatience, resentment and guilt in the patient's mind. This scenario may develop into a sadomasochistic collusion with the patient (Cassorla 2007).

The 'moral' superego can disturb his willingness to be receptive and containing, and hence his ability to tolerate the unknown and uncertainty.

Without the support of the ego ideal and under pressure of the superego, '*not knowing*' is experienced as an internal persecuting object and is replaced by the '*already known*', which relies on memory, wishes, theories and beliefs - against the struggles of learning (Bion 1962). In describing the analyst's process of coping with failure, Money-Kyrle wrote that the degree of disturbance due to the failure to succeed and an inability to understand the patient rests with the strictness of the superego. He claimed that failure is experienced as unconscious persecutory or depressive guilt, which prompts the analyst to project the worst things onto the patient and to blame him (Feldman 1997).

Another, manic scenario of countertransferential enactment involves equating the ego with the ego ideal. The patient's projections encourage the analyst to avoid a painful reality and remain unmoved and omnipotent, i.e. to cope well with everything. The patient's projections may also be directed toward a desire to have the analyst be the perfect mother, who will meet all the wishes of the patient and give him a feeling of oneness.

The patient exerts pressure to establish a narcissistic collusion with the analyst, to which the

analyst agrees. The colluded couple aims to avoid contact with pain and anxiety through a manic denial of reality, feeling no loss or separation, and hence an objective point of view. Enactment of the countertransference provides false comfort to the analyst, and his desire to have peace of mind and go through the analysis unscathed strengthens his belief that the analysis is being conducted well and without reproach. Thus, the analyst puts himself in the place of the ego/analytic ideal, which ensures the love of the superego and frees him from the critical one. However, without the support of the ego ideal, the analyst becomes an inaccessible and narcissistic object, closed to infant pain and anxiety. Under pressure from the patient, the analyst enacts a good (ideal) and falsely satisfying object, striving for the patient's satisfaction and elimination of symptoms. Thus, the analyst avoids being the bad one or (and) a helpless or (and) furious object. Along with 'feeling ideal', the analyst loses his ability to observe himself in the relationship with the patient and use countertransference. He ceases exploring, doubting and raising questions to himself. Like Money-Kyrle (1956), Brenman-Pick (F. Davids 2018) indicates that an analyst who idealizes himself and deifies the idealization of the profession becomes more prone to suffering persecutory guilt and a sense of failure, which may intensify the analyst's feeling of helplessness more than it should. This, in turn, may hurt his narcissistic wound and induce maniacal denials and omnipotence. Many authors emphasize that progress in analysis can be destroyed by narcissistic ambition and an overly personal involvement of the analyst in the relationship (Rosenfeld 1987, Brenman 2006).

Finally, in the melancholic scenario, the superego's countertransferential tormenting of the ego is so intense that the analyst experiences helplessness and resignation. The ideal of the ego/analytic work becomes a source of pain because it is not being achieved or approximated. The analyst becomes despondent, engulfed in self-accusations, guilt and the depreciation of his work with the patient (and even his status as an analyst), and is filled with feelings of powerlessness and malaise. It is quite discouraging and depressing for the analyst to be aware of actual enactments, the impossibility of understanding the patient and what the countertransference conveys. And the mourning process after enactment can be interrupted by manic defence mechanisms. The analyst may search for a quick repair to the enactment or change its significance and, as a result, it becomes something that never happened. Usually, the analyst and the patient escape from the mourning into a collusion of

a seemingly good and productive relationship. The cycles of melancholy and mania with unsuccessful attempts to establish contact with reality and rebuild the relationship with the ideal can last a long time and plunge the analysis into an impasse. An inability to handle the mourning disturbs the ability to distinguish the self from an object creating symbols (Segal, 1957).

However, the willingness to experience such disturbances in countertransference and the internal work of the analyst facilitates a better understanding of the patient, the analyst himself and the relationship of both. In the process, the analyst recovers the ego ideal as a separate object of aspiration, which feeds his analytic function, enables symbolic thinking and helps in coping with countertransference.

Therefore, working through a countertransferential enactment becomes exceptionally important both for the course of further work with the patient and for the analyst's development. This is quite a vast area requiring a separate discussion; however, it should be pointed out here that recognizing an enactment (which is possible only in retrospect) opens the complex process of working through, which involves not only mourning but also manic denials, melancholic doubts, and moralistic exaltations. Finally, it brings us closer to relinquishing the feeling of being a perfect analyst using a perfect method, as well as a belief that we can always tolerate countertransference.

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