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On practising psychoanalytic psychotherapy in the absense of explicit transference manifestations : A clinical enquiry

Da Silva, Linda Jean

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CHAPTER ONE

INTRODUCTION

Since Freud (1893 – 1905) first discovered and described the transference over a century ago, the concept has maintained its status as "the analytic tool par excellence" across the current plurality of psychoanalytic approaches (Berenstein, 2001, p. 141). Having replaced for many the dream as the 'royal road' to the unconscious (A. Freud, 1965; Sandler, Holder, Kawenkoka, Kennedy & Neurath, 1969), the transference has also remained a key concept in distinguishing psychoanalysis and psychoanalytically oriented psychotherapies from all other kinds of psychotherapeutic interventions (Stone, 1951; Gill, 1951, 1962; Szasz, 1963; Ehrenreich, 1989; Kernberg, 2001;).

Despite being surrounded in controversy and debate, transference analysis is still considered the most important focus in psychoanalytic work today (except among the Lacanian perhaps) and transference interpretation the most important means of effecting intrapsychic change (Bird, 1972; Schwaber, 1990; Cooper, 1992; Kernberg, 1993, 1999; Riesenberg-Malcolm, 1995; Galatriotou, 2000).

Without dispute, transference analysis and interpretation is the stuff of psychoanalysis in its classical form, its contemporary varieties and psychotherapeutic derivatives (Freud, 1912; Gill, 1951, 1982; Klein 1952; Straker, 1986; Kernberg 1999; Galatariotou, 2000;). That the concept refers to the transference of relations with significant childhood figures onto the figure of the analyst is unanimous (Greenacre, 1954; Zetzel, 1965; Joseph 1985; Adatto, 1989;). Also agreed is the basic psychoanalytic tenet that people tend to repeat past reactions in present situations in terms of early experiences with primary caregivers without awareness of doing so (Ehrenreich, 1989).

In so far as the notion of unconscious mental functioning is fundamental to psychoanalytic thought, the notion of transference, as a key means of observing unconscious processes is fundamental to psychoanalytic practice of whatever persuasion.

In light of the centrality of the transference, I was therefore intrigued by the work of a number of analysts who have documented their experiences of working psychoanalytically with patients whose transference or capacities for object relating are described in ways suggestive of absence or 'feelings' of blankness in the transference.

In documenting her work with a particular group of patients or 'clinical family' as she calls them, McDougall (1978), for example, describes the transference in these cases as "destined to be still born" (p. 254). Similarly, Quinodox (1996) documents working with a patient whose internal objects she describes as "non-existent" (p. 323), and the transference consequently as "indifferent" (p. 324).

Still other analysts, describing their work with similar kinds of patients in analysis, capture the notion of absence or 'feelings of blankness' in their descriptions of the transference as being: "lack[ing in] real emotional contact" (S. Klein, 1980, p. 396); "autistic" (Kanner, 1944; Liberman, 1958; Roderique, 1966 cited in Gomberoff, Noemi, Pualuan De Gomberoff, 1990, p.252); "dead" (Ogden, 1995, p. 693); "devoid of meaning" (Eshel, 1998, p. 1120); and "the unbearable presence of nothing" (Emanuel, 2001**,** p. 1075).

A common clinical feature among the kinds of patients described in this literature centres around their difficulties in making or demonstrating emotionally meaningful contact with the analyst. These kinds of patients also appear not to be affected or influenced by interpretations. In some cases, while the analytic process can appear to be proceeding, it is usually not accompanied by any significant psychic change. Real psychic change appears to be very difficult, if not impossible, to effect with interpretative work among these kinds of patients (McDougall, 1978; S. Klein, 1980; Quinodoz, 1996; Eshel, 1998; Emanuel, 2001)

Included in this group or 'clinical family' are Betty Joseph's (1975) patients who are "difficult to reach"; Steiner's (1993) patients who withdraw into "psychic retreats"; Meltzer's (1992) "claustrum-dwellers"; and those described by Kanner (1944) "where the 'analyst object' does not exist for the patient, yet the patient's inner world is perfectly clear and visible to the analyst but absolutely inaccessible, as if there were a glass in between" (in Gomberoff; Noemi & Pualuan De Gomberoff, 1990, p. 252).

Although Joseph (1975), Steiner (1993), Meltzer (1992) and Kanner (1944) do not write about absent, missing, dead, non-existent transference per se, they refer to their patients' underlying failed capacities for emotional connectedness and object relating in ways that are suggestive of the notion of transference that appears absent or 'feels' blank. It is for this reason that I have grouped Joseph's (1975) patients who are "difficult to reach", Steiner's (1993) patients who withdraw into "psychic retreats", and Meltzer's (1992) "claustrum dwellers" among the kinds of patients described in the literature on transference that appears absent or 'feels' blank.

There are still other kinds of patients written about in the international psychoanalytic literature who present with similar clinical features. These include McDougall's (1984) "disaffected" patients; Oelsner's (1987) "scattered"; and Bollas' (1987) patients suffering from what he refers to as "normotic illness". Tustin's (1980; 1981; 1986; 1990) notion of "autistic objects" as barriers in neurotic patients has played a major role in drawing attention to these kinds of patients in analysis.

While the notion of transference that appears to be absent or 'feels' blank intrigued me, I was equally intrigued to find that the analysands described in this literature were neither psychotic nor the analysts strictly Freudian. My interest was piqued even further upon discovering that while most of the reporting analysts were of either Kleinian or Object-Relations persuasion, they were describing patients whose internal objects appeared missing (McDougal, 1978); non-existent or absent (Quinodoz, 1996); dead (Eshel, 1998), difficult to reach, (Joseph, 1975) or inaccessible (S. Klein, 1980).

Despite Melanie Klein's (1952) contention that object relations are present from the very start of life, these analysts were describing patients whose object relations, like that of the transference, appeared absent, 'felt' blank, difficult to reach or inaccessible.

On the one hand, while these analysts were describing patients who in terms of their capacities for object relating evinced an 'objectless' state akin to Freud's (1914) primary narcissism, they were at the same time neither psychotic nor seemingly unsuitable for treatment by psychoanalysis. In terms of apparent ego functioning, these kinds of patients all seemed highly functional. Fulfilling occupational positions of both intellectual and social esteem these patients all appeared very suitable candidates for psychoanalysis.

Also very interesting, but on the other hand was that while these kinds of patients all seemed to be functioning within an 'objectless position', this aspect of their clinical presentation seemed to defy the very theoretical underpinnings guiding their analysts' Kleinian or Object-Relations orientations.

Since "object relations are the core of psychoanalytic work – they are the stuff of the transference" (Joseph, 1986, p. 203), and the transference in turn is the stuff of psychoanalysis, I was wondering, in theory at least, and from a Freudian perspective, how psychoanalysis proceeds with patients seemingly incapable of object relating and hence also transference, and who, for this reason would be considered unsuitable for psychoanalysis. From a Kleinian perspective, I was wondering how analysis proceeds with patients functioning within a 'position' that in theory is impossible to conceive of? If transference analysis and interpretation is the stuff of psychoanalysis both Freudian and Kleinian, then I was wondering what other 'stuff' could be the subject of analysis and interpretation in the seeming absence of transference?

Thus, with the question of absent transference in mind, I was interested in exploring this phenomenon further within a local South African setting in which psychoanalytic psychotherapy rather than psychoanalysis is predominantly practiced.

Since psychoanalytic psychotherapy is considered one of the most important derivatives of what could be called psychoanalysis 'proper' (Stone, 1951; Rangell, 1981; Kernberg, 2001), exploring how local psychotherapists practice in the seeming absence of transference seemed important and justified. I was curious to know if any of the local practicing therapists had experienced working with the same kinds of patients described in this interesting literature and if so, then how they worked.

To clarify this seemingly paradoxical idea of absent transference among otherwise functional patients, the research question was written in the form of an e-mailed letter and sent to a local data-base of registered psychoanalytic psychotherapists practicing in the Gauteng region of South Africa. An extract of this e-mail read as follows:

> In partial fulfillment of the requirements for my master's degree in clinical psychology at Wits, I am currently conducting qualitative research in a relatively under-researched area of psychodynamic therapy. I am writing to you in the hope that you might be able to help me in this regard.
>
> The particular focus of my research centres on psychodynamic therapists' experiences of and thoughts about working with a patient where the transference appears to be absent or 'feels' blank. As distinct from overtly psychotic and narcissistically organized patients, classically considered unsuitable for analysis because of their failure to produce transference, I am interested in researching work with patients otherwise considered good candidates for in-depth work.
>
> To elaborate a little, I am interested in finding out what therapists do and think when they do not experience themselves as inheriting in the room affects, roles, positions or object relations (or any of these) that come from 'somewhere else' – from the past or other significant figures or situations for example.
>
> If you have experienced or are experiencing working with such a client, then I would really appreciate your participation in my research and the opportunity of interviewing you about your experience.

Upon posing this research question, however, I was struck by the absence of responses and intrigued even further by the range of the few that I did get. From among the prospective interviewees who responded to my request for participation, there were some who said that while the question sounded very interesting they were not sure that they

knew what I meant by it exactly. Others said that they would think about it and get back to me with their thoughts on the topic. They never did.

There were some too who said that working in the absence of transference or internal objects with patients neither psychotic nor unsuitable for treatment had never been part of their clinical experience. Regretfully on these grounds they declined the invitation to participate in this study, which nevertheless some said, "sounded very interesting".

Still others wondered how I could ask such a question in the first place since the notion of 'absent' or 'blank' transference was inconceivable to them. They seemed perplexed by the question and some even voiced their concern that, clearly, in asking it, I did not seem to know this 'fact'.

While my interest in this topic was rapidly growing, so too was my concern. I was struggling to recruit contributors and time was not on my side. Since this phenomenon had been written about and appeared well documented over the years by well-known psychoanalysts, I was surprised to learn that amongst some of the foremost and experienced local therapists who I approached, it seemed that not one had experienced, in all their years of practice, a patient of the kind that resembled those described in this particular literature. It, therefore, seemed more than likely that there was a problem in the way that I was formulating the question and that the reasons for my interest in this phenomenon were emerging as the very ones at the heart of my difficulties in recruiting contributors.

The fact that the notion of 'absent' transference or internal objects was either confusing to some or difficult to conceive of by others seemed suggestive of the complexity of the concept that I had not anticipated at first.

That there were some who did not feel comfortable in participating in this study seemed reflective of the historically contentious divide between those for whom the notion of

absent transference raises the question of analysability (the Freudians) and those for whom it is inconceivable (the Kleinians).

While the notion of working psychoanalytically in the seeming absence of transference remained intriguing to me, the problem that this notion posed in terms of recruiting possible contributors was moving rapidly into the foreground of my mind. With an unresolved theoretical riddle, more questions to answer than when I first started out, and the problem of finding contributors to possibly answer some of them, I returned to the drawing board so to speak and started reading more literature.

With the particular aim of trying to find out how well-known Kleinian and Object-Relations oriented analysts could describe working with patients whose clinical presentations seemed to defy the very theoretical underpinnings of their orientations and why I could not ask this question locally, I came across Ogden's (1989) interesting work and theorizing in this area. Based on his observation and experience in the clinic with the kinds of patients who appear to contradict the very theory informing Kleinian-cum-Object Relations practice, Ogden postulated an "autistic contiguous position" (p. 127).

By theorizing a position that predates Klein's paranoid-schizoid position and resembles Freud's notion of primary narcissism in which state according to Ogden (1989) "mother and infant are one", he not only seemed to rescue Kleinian theory from this apparent clinical anomaly, but in doing so made what was practically possible to observe in the clinic, theoretically possible to conceive of among Kleinian and Object-Relations analysts.

However, despite this 'find', it still did not resolve either the problem of recruiting contributors or account for the fact that while these patients' occupational functioning appeared to place them on the high end of the intellectual continuum, their intrapsychic functioning, at least in terms of object relating, seemed to place them practically back in the womb and seemingly outside of the therapeutic reach of psychoanalytic treatment of any kind (at least in so far as interpretative work was concerned). Also, on the basis of

the responses to my question, it seemed clear that most prospective interviewees were not aware of Ogden's (1989) concept of an "autistic contiguous position" more primitive than Klein's (1946) paranoid schizoid one.

For most prospective interviewees therefore, the Kleinian (1952) idea of object relations from the very start of life, all be they split and paranoid, remained in tact and the notion of 'absent' objects and hence also transference both inconceivable and counter to local clinical experience. The possibility of finding contributors to report on their experiences remained nil and the theoretical 'find' I thought resolved this theoretical riddle in part - at least from a Kleinian perspective, merely led me into a practical cul-de-sac.

In order to study the notion of absent transference, it was becoming increasingly apparent that I was going to have to find out what is *actually* meant by the transference in practical terms and in therapy itself. The possibility of doing this research hinged on finding a *working definition* of the transference in order to formulate a notion of its apparent absence in a way that both bypassed the question of analysability *and* the problem of inconceivability. I was going to have to get past the Freudians and the Kleinians, so to speak.

However, as my failed efforts in recruiting contributors to this study so far had proven, and as a closer and wider perusal of the literature confirmed, the transference is not a single concept at all (Ehrenreich, 1989).

Despite its singular use as a central concept and analytic tool par excellence across the variety of psychoanalytic approaches, conceptualisations range from the classical understanding of transference as a repetition of the past in the present (Freud, 1915a), to the notion of the transference as 'co-created' in the present analytic situation (Gill 1982; 1983; Hoffman, 1991); from a distortion of reality and an inappropriate response to the figure of the therapist (Greenson, 1965), to the notion of the transference as "plausible conjecture" and the patient's response to something real about the figure of the therapist (Jordan, 1992; Renik, 1992).

Still other notions of transference include psychotic transferences, borderline transference (Kernberg, 1976), part and whole object transferences (Lafarge, 2000), self-object transference, background transference (Grotstein, 1993), transference-like phenomenon and basic transference (Ehrenreich, 1989).

While understandable in principle, the tendency amongst Freudian analysts to distinguish the transference from the 'non-transference' relationship (Greenson &Wexler, 1969), the working alliance (Zetzel, 1956); or 'real' relationship (A. Freud, 1965) brought me no closer to a practical or working understanding of the concept.

The Kleinian idea, like that of Betty Joseph (1985, p. 447), that the transference refers to "everything the patient brings into the relationship" seemed too broad to constitute a workable definition for the purposes of formulating a notion of its absence.

Drawing on my theoretical background rooted in Freudian thought, clinical training influenced by contemporary Kleinian and Object Relations practitioners, and reading of some of the major analysts like Winnicott, I started asking myself what it is that a patient will *actually* do or say in the room that would make me know, for example, that what was happening was transference. What exactly will a patient do or say that will make me know that I am being related to as a figure from the past and not a real figure in the present? And, if the patient is responding to something real about me, then what is transferential about this response? How can it be both realistic and inappropriate, a repetition of the past and co-created in the present? By the same token, if the transference refers to "everything the patient brings" as Betty Joseph (1985, p. 447) tells us, does this mean that everything the patient brings is a distortion of reality and therefore inappropriate in the present?

In as much as the notion of absent transference was proving problematic to research, finding out what the transference actually is seemed no less of a problem (at least from an experiential or practical point of view). Without realizing the implications of the questions that I was asking at the time, the gap between my theoretical knowledge of the

transference and practical experience of the concept was emerging as something quite real and alarming.

Asking a few of my colleagues the same questions that I had asked myself confirmed theoretical rather than practical or experiential understanding of the transference. The gap between *knowing* what the transference is in theory and *experiencing* it in the room was not only my own problem but also something shared among the few trainee therapists that I knew. (I could only imagine the truth of this disparity among trainee psychoanalytic therapists more generally).

For as many definitions of transference in theory, there seemed varieties of psychoanalysis in practice. Ehrenreich's (1989) article entitled, *"Transference: one concept or many?"* seemed to echo Wallerstein's (1988) paper *"One Psychoanalysis or many?"* presented earlier in 1987 at the International Psychoanalytic Association Congress in Montreal.

In asking what the transference actually is, it seemed that I was in essence now asking what psychoanalysis actually is. From my original aim of exploring the notion of absent transference, I now appeared to be exploring what constitutes psychoanalytic practice itself.

While this leap might seem the obvious one to have made given that the transference is the stuff of psychoanalysis (so that asking about the transference is in essence asking about psychoanalysis), it was, however, within the context of my question on absent transference that the notion of what constitutes psychoanalytic practice emerged as a question of seemingly equal complexity as the notion of transference itself. For now, in the midst of the current range of transference definitions and the plurality of psychoanalytic approaches, I was trying to identify which particular understanding of transference could, as it were, by definition be absent and which particular version of psychoanalysis at stake because of it?

Thus, in addition to attempting to explore the phenomenon of absent transference with all of its implications for psychoanalytic theory and practice, finding a working definition of the transference in order to formulate a researchable question around its absence became a primary aim in getting this project off the ground so to speak.

After several failed efforts of trying to define the transference in order to formulate a researchable question around its absence, I embarked on a somewhat detailed review of the literature on transference with a particular focus on how the transference manifests in the room.

By tracing the development of psychoanalysis and discovery of the transference as a central analytic tool from Freud's (1983; 1905; 1912a; 1913; 1915a, b; 1917a; 1917b; 197c; 1924; 1926) work with neurotic patients, through Melanie Klein's (1926; 1942) work with psychotic and child patients in analysis to Winnicott's (1947; 1948; 1952; 1955a; 1955b; 1956; 1958a, 1958b, 1960a, 1960b, 1963a, 1963b; 1971) work with borderline patients, it emerged that the transference manifests differently among different kinds of patients functioning at different developmental levels and using different mechanisms of defence.

This literature revealed that the transference of neurotic patients manifests very differently from that of borderline, psychotic or child patients in analysis. More specifically, it revealed that the nature of unconscious material being transferred as well as the mechanism by which it is transferred appears to influence how the transference manifests.

Drawing on Freud's body of work with neurotic patient's in analysis for example, it seemed that the transference of repressed unconscious material that is displaced onto the figure of the analyst tends to manifest explicitly in the room in the form of the patient's erotic attachment to the analyst – the patient's love in transference (Freud, 1915a).

By contrast, drawing on Melanie Klein's (1926; 1946; 1952) work with psychotic and child patients in analysis, it seemed that the transference of split off unconscious material that is projected into the figure of the analyst tends to manifest implicitly in everything the patient brings into the room. It seemed in other words that the transference among psychotic or child patients does not necessarily manifest in the form of direct/explicit references to the analyst, but can also be indirect/implicit in the patient's references to everyday experiences, situations and interpersonal relations that occur outside the room.

It was therefore on the basis of my reading of Freud and Klein's varying understandings of the mechanisms by which unconscious material is transferred that the idea of a difference between explicit transference and implicit transference manifestations occurred to me.

From Freud's (1915a; 1917) work for example, it seemed that when repressed unconscious material is displaced onto the figure of the analyst, the transference tends to manifest explicitly in the form of direct references to the analyst. From Klein's (1952) work by contrast it seemed that when split off unconscious material is projected into the analyst, the transference does not necessarily manifest in explicit references to the analyst but can also manifest implicitly in the form of the analyst's subjective experience of the patient's split off unconscious material.

This idea, that parts of the patient are split off and projected into the analyst, refers to Klein's (1946) concept of projective identification. Projective identification according to Klein (1946) refers to the process by means of which parts of the subject are projected into and then attributed to an external object. It defines the most primitive form of object relating, prior to subject-object differentiation and the acquisition of language. Projective identification is thus a 'silent' or non-verbal means of communicating with the object and defines what Bion (1957) referred to as the patient's "unconscious communication" (Ogden, 1995).

As a primitive mechanism of transferring unconscious material, projective identification lends even further support to, and justification for, the idea that transference manifestations are not limited to direct references to the figure of the analyst but can manifest implicitly in the analyst's subjective experience of the patient's split off unconscious material.

It was therefore on the basis of this idea of a distinction between explicit and implicit transference manifestations, founded as it was on reading complex theory, that a working definition of the transference and a researchable formulation of its absence that both bypassed the question of analysability and the problem of inconceivability emerged.

For the purposes of this study, a working definition of the transference, based on the idea of explicit transference manifestations, was defined as the patient's direct verbal and affectively intense references to the figure of the analyst.

This working definition of the transference allowed for a researchable formulation of its absence to emerge with the result that four practicing clinical psychologists working in a psychodynamic/analytic orientation agreed to share their experiences of, and thoughts about, working with a patient (or patients) who never makes any directly verbal and affectively intense (either positive or negative) references to the figure of the therapist.

Instead of exploring the phenomenon of transference that seems absent or 'feels' blank in other words, the research question now focused more specifically on exploring psychodynamic psychotherapists' experiences of, and thoughts about, practicing psychoanalytically oriented psychotherapy in the absence of what I referred to as explicit transference manifestations. In so far as this formulation was based on a distinction between explicit and implicit transference manifestations, the aim of this study emerged as being as much about exploring and describing how local therapists practice psychoanalytic psychotherapy in the absence of explicit transference manifestations as it was about how they practice in the presence of implicit transference manifestations – (i.e., the non-verbal dimension of the transference).

It is important to note that while the formulation of 'absent' transference for the purposes of this study is based on the very broadest possible working definition of how transference material might manifest in the room, this formulation does not preclude more contemporary debates as to what actually constitutes transference, the real relationship or what from an intersubjectivist perspective might be considered to be 'co-created' between the patient and the therapist in the room. For example, not every explicit verbal or affectively intense reference to the figure of the therapist is necessarily regarded by all therapists as transference, and, in terms of the idea of a distinction between explicit and implicit transference manifestations, an absence of explicit transference does not necessarily indicate or signal an absence of transference per se.

In addition to the importance of distinguishing between an absence of explicit transference and an absence of transference generally, it is also important to consider the difference between an absence of explicit transference manifestations as a result of the patient's resistance to the transference (Gill, 1979) and an absence of transference resistance because of so called underlying missing, absent, dead or non-existent internal objects.

It is with all the limitations of this working definition of transference and formulation of its absence that this study begins with a review of the literature on transference by tracing the history of the discovery of the concept and its role as a central analytic tool in making the unconscious conscious and in determining a patient's analysability.

The nature and role of the transference, its relation to the neurotic symptom as well as its resolution is included to show why the transference is a central analytic concept and why psychoanalysis, as Freud (1912) originally described the process, depends on the patient's capacity for transference.

Klein's (1952) work is then reviewed to show that while the transference is defined differently, it remains a central concept, and why according to her view of development

the idea of absent transference is inconceivable and does not therefore raise the question of analysability.

Winnicott's (1955) work is reviewed to show that the transference manifests differently depending on the status of the integrity of the patient's ego and that different therapeutic techniques are called for among patients demonstrating different degrees of ego integrity.

Winnicott's (1960a) work emerges as being of particular importance and relevance to this study in so far as a conceptualization of absent transference treatable by a technique that can still be called psychoanalytic is derived from his work and in particular from his formulation of pathology in terms of a false/true-self split.

While the review of Freud and Klein's work on the centrality of transference analysis and interpretation shows why it is difficult in a contemporary setting to ask a question about absent transference among the kinds of patients who present as seemingly suitable candidates for psychoanalysis, it is on the basis of a close reading of Winnicott's work that a question on absent transference seems not only plausible but indeed an important one to ask contemporarily.

A review of the contemporary literature on apparent absent transference provides further justification for the research question. It is in this work that the difficulties described by the reporting analysts in detecting and treating the kind of psychopathology manifest in an absence of transference among patients seemingly suitable candidates for psychoanalysis appear reflected in my difficulties in formulating a question that captured this idea among psychotherapists practicing psychoanalytic psychotherapy locally in a South African setting.

CHAPTER TWO

LITERATURE REVIEW

2.1 Freud - The development of psychoanalysis and the discovery of the transference

Many of the key elements that make up the concept of the transference can best be illustrated by tracing the history of early psychoanalytic technique. For this reason, this section comprises a somewhat detailed review of the context in which Freud (1893-1895) developed psychoanalysis. The shortcomings of hypnosis are included in order to highlight how the abandonment of this early clinical method finally lead Freud (1893, 1905, 1910, 1912a) to recognize the importance of the patient's emotional attachment to the figure of the analyst and his discovery of the phenomenon of the transference, which functions paradoxically as the patient's most powerful resistance against the aims of the treatment and consequently as the analyst's most powerful psychoanalytic tool as a 'royal road' to the unconscious.

Freud's psychoanalysis first developed as an alternative method to hypnosis for the treatment of hysterical phenomena, or physical symptoms for which no underlying causes could be found. The history of its development is rooted in the discovery of a series of obstacles related to the fact that hypnosis worked in the short term but could offer no lasting cure for neurotic symptoms (Strachey, 1955).

By tracing the origins of hysterical symptoms to precipitating events most commonly experienced in a forgotten childhood past, psychoanalysis became what Strachey (1955, p. xvi) describes as "the first instrument for the scientific examination of the human mind". As a means of demonstrating the controversial notion that symptoms without an apparent physical cause can have an unconscious symbolic meaning, one of the chief aims of psychoanalysis was formulated, namely that of making the unconscious conscious.

While the psychoanalytic understanding of unconscious mental functioning derived from the intriguing observation that patients under hypnosis tended to remember traumatic events otherwise forgotten in normal waking states, the curative effects of making the unconscious conscious derived from the equally intriguing observation that symptom resolution often followed remembering and reliving, with full affective intensity and detailed narration, these otherwise forgotten traumatic experiences. For this reason, Freud (1893, p. 7) believed that "hysterics suffer mainly from reminiscences". He regarded hysterical symptoms as mnemic symbols or 'monuments' of forgotten pathogenic memories resulting from the damning up of unexpressed affects associated with a series of related traumatic scenes (Freud, 1910, p. 16).

The idea that symptoms arise from residues or precipitates of emotional experiences or psychical traumas (Freud, 1910**)** appears to be what established the basic psychoanalytic tenet that the past influences the present or remains active in the present in the form of hysterical symptoms. The observation that the removal of such symptoms depended on the reproduction of the "whole chain of pathogenic memories in reverse order, the latest ones first and the earliest ones last" appears to have been the forerunner of the psychoanalytic idea of making the unconscious conscious by filling gaps in the patient's memory (Freud, 1910, p. 14). It also seems to have underlined the reason for referring to this kind of treatment as the "talking cure" or "chimney sweeping" (Freud, 1893, p. 30).

While impressed with the cathartic effects of remembering and abreacting under hypnosis, Freud, however, remained frustrated with the fickle nature of this technique. Not all patients were amenable to hypnosis and Freud did not always succeed in inducing this state in all who came for treatment (Strachey, 1955). Also, despite some very striking results among the few patients who were amenable to hypnosis, these were most often short lived and in some patients appeared to establish an unhealthy dependence on both the procedure and the doctor (Freud, 1917b).

Another drawback of hypnosis was that it was taxing on physician and patient alike, requiring of the former great dedication, perseverance and patience and of the latter the

kind of confidence and trust that many seemed neither able nor willing to demonstrate. For as many patients who developed a dependence on the technique and the physician, there were those who abandoned both as soon as the process led "to the disclosure of their most intimate and secret psychical events" (Freud, 1893, p. 265). Among the kinds of patients for whom the physician remained a stranger, hypnosis was without consequence.

It did not take Freud long to realize that the 'magic' behind the success of hypnosis among some patients lay in the relationship and the degree to which the doctor became for them a close and influential confidante. Among those for whom the doctor remained a stranger and hence without influence, the process, however, remained doomed to fail. While Freud's notion of the transference was clearly in the making at this stage, it was not until much later that its privileged place as a royal road to the unconscious in psychoanalysis was to be secured.

In the mean time, with all the limitations of catharsis via hypnosis and driven by practical considerations, Freud (1893) found himself working without hypnosis and treating more patients as a result. However, no sooner than Freud (1893, p. 270) replaced hypnosis with 'insistence' to remember with a little pressure to his patients' foreheads, than he encountered the same resistance to remembering the pathogenic associations as that of some patients to hypnosis. Clearly, what had worked among those amenable to hypnosis was the fact that while under the authoritative influence of the doctor, remembering had taken place without resistance.

What Freud (1893) had always considered a drawback of technique now emerged as intrinsic to the very nature of the symptoms he was trying to treat. For the same psychical force opposing pathogenic ideas from becoming conscious or from being remembered was the very one involved in generating the symptom in the first place.

Manifesting in the form of resistance, Freud (1910, 1917c) named this force opposing remembering and the process of this special kind of forgetting, "repression". According

to Freud's (1910, p. 24) psychoanalytic researches, the motives for repression involved excluding from consciousness "a wishful impulse which was in sharp contrast to the subject's other wishes and which proved incompatible with the ethical and aesthetic standards of his personality". Most often these wishful impulses were of the kind that caused the person to experience shame, disgust, self-reproach or psychical pain. Without exception they derived from some aspect of the person's erotic or sexual life, the traces of which invariably led back to impressions laid down in early childhood, involving the patient's parental figures and belonging to what Freud referred to as the Oedipus complex (Freud, 1912b).

While controversial, the idea of infantile sexuality and its role in the aetiology of the psychoneuroses was to become one of the corner stones of Freud's (1906) theory. For increasingly, as psychoanalytic research began to show, repressed unconscious wishes had once been conscious infantile ones and that falling ill as a result of the conflict between the libido and their sexual repression was a conflict modelled on a much earlier struggle between the sexual instincts striving for satisfaction and those acting in the service of the demands of reality (Freud, 1910).

Seen in this light, neurotic symptoms were no longer mnemic symbols of forgotten pathogenic memories of traumatic experiences, but expressions of the fate of the repressed sexual instincts and consequent damned up libido having been denied satisfaction from objects in the real world.

As substitute satisfactions, neurotic symptoms marked the return of the repressed in disguised form. Repressed wishful impulses had turned into symptoms, and so the task of analysis became one of transforming symptoms back into the repressed ideas they symbolized (Freud, 1910, 1917c). The aim of analysis was thus to release the libido maintaining the symptom and to make it available once more to the patient's ego to find satisfaction along more socially acceptable lines (1910, 1917b, 1917c).

Technically, instead of filling gaps in the patient's memory by tracing the origins of symptoms to the series of precipitating traumatic events and fortifying the patient's resistance by removing the effects of the noxious agency, the means of filling gaps in the patient's memory became one of removing the patient's resistance to remembering the reproachable wishful sexual impulse (Freud, 1893; 1912a).

Accordingly, analysing resistance became one of the chief means of lifting the patient's repression and revealing the pathogenic wishful impulse underlying the formation of the symptom. Instead of removing the effects of the symptom via catharsis, the aim of the treatment became one of rendering the unconscious wish conscious (Freud, 1917c).

Thus relying on the patient's resistance to point the way to the repressed unconscious material, Freud (1910) abandoned insistence and the 'pressure' technique by establishing the fundamental rule of psychoanalysis. In accordance with this rule, Freud requested his patients to free associate without censorship – to put aside their will so to speak and begin the process with whatever idea came to mind (Freud, 1910).

Whereas Freud (1893) had previously relied on the influence of the doctor for suggesting the effects of hysterical symptoms away, he now depended on the influence of the doctor to overcome the patient's resistance to associate freely anything and everything that came to mind no matter how irrelevant, embarrassing or unimportant it seemed. For just as the success of hypnosis rested on the patient's favourable relation towards the analyst, so too was this related to the extent to which the patient obeyed the fundamental rule of psychoanalysis.

Writing about the significance of the patient's favourable relation towards the analyst, Freud (1926, p. 224) argued that,

> This personal influence is our most powerful dynamic weapon…the neurotic sets to work because he has faith in the analyst, and he believes him because he acquires a special emotional attitude towards the figure of the analyst…

> I have already told you what use we make of this particularly large 'suggestive' influence. Not for suppressing the symptoms – that distinguishes the analytic method from other psychotherapeutic procedures – but as a motive for to induce the patient to overcome his resistances.

Thus, so long as the patient maintained a friendly and co-operative attachment to the analyst, associations flowed freely, failing which, the resistance gained the upper hand and associations would dry up. Under the influence of resistance rather than that of the doctor, the patient would claim that nothing further came to mind. It was for this reason that overcoming the patient's resistance became the essential function of psychoanalytic treatment and the sole means by which the analyst could attempt setting the process back on track and gain the upper hand over the patient's resistance once more (Freud, 1917c).

However, no sooner had Freud (1910) recognized the power of the patient's emotional attachment to the doctor and the doctor's influence because of it in overcoming the patient's resistance to free associate and produce the ideas from which to trace the repressed unconscious material than he came up against a further obstacle.

With uncanny regularity and without any provocation on the part of the doctor or rational explanation for it (Freud, 1910), the patient's emotional attachment to the doctor intensified over time during the treatment and assumed the nature of falling in love.

What had once been the doctor's most powerful dynamic weapon in overcoming the patient's resistance had turned into the patient's "most powerful resistance to the treatment" (Freud, 1912a, p. 101). For instead of resisting the process of remembering by claiming that nothing further came to mind, the patient's resistance emerged in the form of falling in love with the doctor and claiming to be no longer ill. In the place of the symptom for which the patient had originally sought cure, Freud (1912a) encountered the condition of love for which the patient now sought satisfaction.

While the patient's love for the analyst represented the most powerful weapon against the aims of the treatment, it did not take Freud long to determine what was actually happening. In this regard, Freud (1926, p. 226) writes that,

> And now we understand what is happening. The patient is repeating in the form of falling in love with the analyst mental attitudes that were lying ready in him and were intimately connected with his neurosis. He is also repeating before our very eyes his old defensive actions; he would like best to repeat in his relation to the analyst all the history of that forgotten period of his life. So what he is showing us is the kernel of his intimate life history; he is reproducing it tangibly, as though it were actually happening, instead of remembering it.

As Freud (1915a, 1926) discovered, the patient had in fact been in love for a long time. This love was not something new but belonged to the patient's remote past and to a significant figure – invariably one of his/her parents. To this special kind of love Freud gave the name "transference".

The frequency with which Freud (1926) observed the transformation of every neurosis into a condition of pathological love also left little doubt in his mind that the work of analysis had the effect of "driving out one form of illness with another". It was to the patient's neurotic illness, transformed in the analytic setting, that he gave the name "transference neurosis" **(**Freud, 1926, p. 226)

Under these new circumstances, while the task of analysis until this point had been the removal of the patient's resistance to remembering the reproachable wishful impulse underlying the symptom, the task was now to remove the patient's transference resistance which manifested in the form of falling in love with the analyst by making the patient recognize that he/she was merely repeating the "prototype of his transference-love in his childhood" (Freud, 1910)**.**

According to Freud (1926, p. 142), the task becomes one of convincing the patient

> …that he is not in love but only obliged to stage a revival of an old piece. Everything depends on that and the whole skill in handling the transference is devoted to bringing it about. The requirements of analytic technique reach their maximum at this point. The only way out of the transference situation is to trace it back to the patient's past, as he really experienced it or as he pictured it through the wish-fulfilling activity of his imagination.

By understanding the patient's love as a revival or repetition of the past and then subjecting it to analysis and interpretation, Freud was able to transform what at first represented the most powerful resistance against the aims of the treatment into the most powerful analytic tool in bringing about its resolution – in making the unconscious conscious.

It is perhaps important to note at this point that while Freud encountered and wrote about the significance of the patient's emotional attachment to the figure of the analyst in his earliest case studies, it was not until his analysis of Dora in 1905 that he officially defined the transference. According to Freud (1905, p. 116),

> Transferences are new editions or facsimiles of the impulses and phantasies which are aroused and made conscious during the progress of the analysis; but they have this peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the physician. To put it another way: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment.

2.2 Freud - Kinds of transferences and their features

In the very broadest sense, the transference refers to the patient's relation or emotional tie to the analyst. Freud (1913), however, differentiated the patient's emotional tie into what he described as the mild positive transference, the positive erotic transference and the hostile transference. For Freud (1912a, p. 105), the mild positive transference is admissible to the patient's consciousness. It serves the interests of the analysis and according to Freud is the vehicle upon which the success of the treatment depends. The mild positive transference is important to establish and maintain throughout the analytic process because it imbues the analyst with influence in motivating the patient to overcome his/her resistance to the process.

It is important to note that while Freud (1912a) referred to the realistic aspects of the patient's relation to the analyst as the mild positive transference, his contemporaries have referred to it variously as the real relationship, the transference-free, non-transference (Greenson & Wexler, 1969), working or therapeutic alliance. (Zetzel, 1956**).**

In contrast to the real relationship or working alliance (i.e., the mild positive transference), both the erotic and hostile transferences are not admissible to consciousness and do not immediately serve the interests of analysis (Freud, 1912a).

One of the key features of the transference proper, unlike the real relationship or working alliance (the mild positive transference), is that it represents an aspect of the patient's relation to the figure of the analyst that is unrealistic, irrational and unconscious. The transference also differs from the patient's real relationship or working alliance in that it is deemed to be "an indiscriminate, non-selective repetition of the past", a distortion of reality and inappropriate. (Greenson & Wexler, 1969, p. 28).

While the patient's transference feelings towards the figure of the analyst are quite real to the patient, they are a distortion of reality and inappropriate in the sense that they stem from the past and belong to a significant figure or figures in the patient's early childhood and not to the real person of the analyst.

The transference of feelings from a period in the patient's past into the present and displacement of these same feelings from the original object to who they belong onto the figure of the analyst represent a "misidentification" of both place and person. Simply put, transference feelings belong neither to the present nor to the person of the analyst.

Another important aspect of the transference is that the patient is not aware that his/her feelings towards the analyst have a history and an original object. The patient has forgotten or repressed that he/she was, for example, in love with either one of his/her parental figures at a certain point in childhood (Oedipus). Instead of remembering this, the patient repeats it in relation to the analyst so that the analyst can be viewed as the object by displacement of the patient's infantile incestuous fantasies (Zetzel, 1956).

While the transference is one of the most powerful means by which the patient resists the aims of psychoanalytic treatment, it is also paradoxically a key analytic tool. As a repetition of the past, the revival of feelings onto the person of the analyst marks the return of the repressed so that the transference becomes for the analyst a 'royal road' to the unconscious.

Instead of accessing repressed unconscious material via the patient's free associations, dreams and other chance actions, like slips of the tongue, it is via the transference that the repressed unconscious material comes to life to so speak as the patient enacts it in the room and in his/her relation to the figure of the analyst. It is in this sense that "the transference provides the patient with a particular unconscious mode of memory" (Virtue, 1993**,** p.4) and "performs the service of making hidden conflicts immediate, apparent, and available for therapeutic intervention" (Bauer, 1990, p. 6).

Finally, and on a more practical note, the transference tends to manifest clinically as an unprovoked intensification of the patient's emotional attachment to the figure of the analyst that can be either positive or negative. While Freud (1915a) concentrated mainly on the patient's love in transference or erotic transference, he did also mention the transference of hostile feelings on to the figure of the analyst (1917a). The transference in the room therefore is not limited to the transference love, but can be of either the positive erotic or negative hostile kind.

2.3 Freud - The transference inside and outside of analysis.

According to Freud (1910), the transference is not a creation of the psychoanalytic process. Rather, it is provoked by the particular conditions of the psychoanalytic situation. Regarding the development of transference, Freud (1917a, p. 442) writes in his *Introductory Lectures on Psychoanalysis* that,

> We mean a transference of feelings on to the person of the doctor since we do not believe that the situation in the treatment could justify the development of such feelings. We, suspect on the contrary, that the whole readiness for these feelings is derived from elsewhere, that they were already present in the patient and, upon the opportunity offered by the analytic treatment, are transferred on to the person of the doctor.

On the basis of Freud's (1917a, p 447) understanding that neurotics "fall ill in one way or another of *frustration,* when reality prevents them from satisfying their sexual wishes"**,** the readiness of neurotics to transference stems precisely from their unsatisfied libido, which deprived of satisfaction, strives to find objects in the real world (Strachey, 1934).

While a certain amount of unsatisfied libidinal impulses exist in everyone**,** suggesting in turn a universal tendency to transference, in neurotics there is an excess amount of unsatisfied or unattached libido, making their particular tendency to transference in turn correspondingly greater (Freud, 1917d).

According to Freud (1917a, p. 498) for example,

> A capacity for directing libidinal object-cathexes on to people must of course be attributed to every normal person. The tendency to transference of the neurotics I have spoken of is only an extraordinary increase of this universal characteristic.

The neurotic's excess libido, arising as it does from being denied satisfaction from objects in the real world and resulting in the neurotic symptom as a "substitute for their frustrated satisfaction" (Freud, 1917a, p. 445), is the same unsatisfied libido from which the transference onto the figure of the analyst stems.

The preconditions for the readiness to transference among neurotics are the same as those for falling ill with the exception that instead of manifesting in the form of the symptom, the illness manifests in analysis in the form of an erotic or hostile relation to the figure of the analyst – hence the term 'transference neurosis'.

Since the neurotic is denied satisfaction from objects in the real world, their unattached libido withdraws from reality and embarks on a regressive course stirring up infantile imagos into which series the analyst is placed (Freud, 1912a). The analyst, representing the original object from whom libidinal satisfaction was desired and denied at a time in the patient's past (Oedipus), becomes by virtue of this regressive process the object of the patient's libidinal object cathexis in the present. The patient's neurotic illness of the past is in analysis turned into a present day transference neurosis.

From the above, it seems clear that the transference is not created by the analytic process but is rather a manifestation of the patient's neurotic illness in the room. Psychoanalysis and the rules or conditions that govern this special kind of setting, however, make the transference observable or stand out in a way that cannot easily be observed outside analysis. Thus, while psychoanalysis does not create the transference it can be said to influence how it manifests and functions inside the psychoanalytic situation.

Summing the key differences between transference inside and outside analysis, Loewenstein (1969, p. 585) writes for example that,

> By virtue of psychoanalytic technique, transference gets involved in such a way that it is at once a source of resistance and a source of discovery of the warded-off conflict which is being repeated in the transference. These aspects of the transference i.e. its uses both as resistance and as vehicle of discovery and cure – exist exclusively in the analytic situation and can never be observed outside it. The transference character of some facets of object relations and of neurotic behaviour outside analysis can only be inferred.

Writing further on the differences between transference inside and outside analysis, Loewenstein (1969) says that,

> Outside the analytic setting transference can hardly ever reach the same complex development and the same resolution. After all transference in analysis unfolds under controlled conditions, whereas outside it there are real interactions and interferences between people. Transference in analysis is not identical with kindred phenomena outside it.

It is within the context of these so called 'controlled conditions' of analysis, with particular emphasis on the role of the analyst, that Freud's work on the nature, role and management of the transference in the psychoanalytic setting is reviewed.

2.4 Freud - On the nature, role and management of the transference in the classical psychoanalytic situation.

In *On the dynamics of Transference*, Freud (1912a, p. 22) tells us "that the transference arises not just from conscious expectations but from repressed or unconscious ones". The conscious expectations, in the form of the patient's seeking cure from the analyst, arise from what is real about the analyst and what is appropriate in the present, for why else seek analysis.

The conscious expectations constitute the "patient's will to recover" (Strachey, 1934, p. 130). They are the forces in the battle with which the analyst must establish and maintain allegiance. It is these forces that imbue the analyst with influence in motivating the

patient to overcome his/her resistance to the therapeutic process and are for this reason the ones upon which the success of psychoanalysis depends. These forces are the ones that constitute what Freud referred to as the 'mild' positive transference or unobjectionable part of the transference (Strachey, 1934, p. 276), and what others refer to as the real relationship, non-transference or transference-free relationship (Greenson & Wexler, 1969), or working or therapeutic alliance (Zetzel, 1956).

By contrast to the patient's conscious expectations for cure, which constitute the real relationship or working alliance, the patient's unconscious expectations for libidinal satisfaction, which constitute the transference relationship, arise from what is not real about the analyst.

The patient's demands for love are not, as Freud (1915a, p. 161**)** warns, attributable to "the charms of the analyst's own person", but to a significant figure in the patient's early life. These expectations are, therefore, the very ones from which the analyst must exercise restraint. The doctor must in other words conduct analysis in abstinence by keeping what Freud referred to as his/her countertransference in check.

The doctor's restraint plays an important role in establishing the ideal conditions in which the transference can arise spontaneously and become amenable to analysis and resolution. It is by virtue of the analyst's abstinence after all that a cure by love under any other circumstances is rendered amenable to analysis and talking instead.

The classical analyst's neutrality and abstinence not only evokes the situation which originally gave rise to the formation of symptoms (Freud, 1914c, p. 147) - the oedipal situation in relation to the parent, but establishes the conditions under which the patient's unmet expectations or demands for love transform his/her original neurotic illness into a newly created 'transference neurosis' centering as it does around the figure of the analyst (Freud, 1917a).

Freud (1915a) explains that it is the analyst's abstinence that makes the patient's heart grow fonder - fuelling the patient's passions and expectations for love (not forgetting of course that hell hath no fury like a woman scorned); draining cathexes from the original symptoms into the relationship and onto the figure of the analyst. By transforming what was once an intrapsychic conflict into an interpersonal one, the conditions for the battle between the forces seeking recovery and those seeking satisfaction are now set to take place on the same psychological ground (Freud, 1917a). They become as it were amenable to reality and influence because what the patient repressed in the past becomes what he/she repeats in the present – repeating replaces remembering (Freud, 1914c, p. 151).

Thus, instead of satisfying the patient's demands for love, which would surely result in eliminating the forces seeking recovery and therefore also the aims of analysis, the analyst frustrates and fuels those seeking libidinal satisfaction further by establishing the "fundamental rule of psychoanalysis" (1915a, 1914c, p. 288;**)**. By requesting the patient to free associate without censorship, the analyst appeals to the forces seeking recovery to remember. It is at this point, however, that those seeking satisfaction rise up against this request in the form of resistances (Freud, 1917c).

Acting like "*agents provocateur'*, these forces seeking satisfaction, only intensify the patient's passions, replacing at once the 'impulsion to remember' with the 'compulsion to repeat'. In *Observations on Love in Transference*, Freud (1915a, p. 162) writes:

> and this change happens with some regularity, just at the point where you had to require her to admit or recall a particularly painful and heavily repressed part of her life. She had thus been in love for some time, but now the resistance begins to make use of her love to prevent the therapy from continuing, completely distracting her interest from the task in hand

It is precisely at this point, that the analyst joins the battle so to speak. By employing "the art of interpretation…for the purpose of recognizing the resistances…and making them conscious to the patient" (Freud, 1914c, p. 147), the analyst not only keeps his/her countertransference in check, but maintains analytic allegiance with the forces seeking

recovery, arising as they do from the same quarter as the patient's conscious expectations for cure. (It is perhaps in this sense that the analyst betrays the notion of neutrality in the strict sense by siding with reality and joining forces with all that is rational in the patient).

While the parallels between the psychoanalytic situation and that of a confessional are striking, there can be little doubt of the difficulties in confessing any disreputable or unacceptable wish-impulse to the analyst, who unlike the priest, by virtue of the transference, is not only the recipient of the confession but also the object of the repressed erotic or hostile impulses**.** It is for this reason that Freud (1912a) explains why the transference of these unconscious impulses is such a suitable medium for resistance, and, by implication, why the analyst who, unlike the priest offering freedom in the form of forgiveness, must offer consciousness instead.

Freud (1914c, p. 147) tells us that by uncovering the resistances and making them known to the patient, "the patient often relates the forgotten situations and connections without any difficulty". For this reason, he advised psychoanalysts in his paper on *On Beginning the Treatment* (Freud, 1913, p.139**)** and makes the all important technical point regarding the transference that:

> *So long as the patient's communications and ideas run on without any obstruction, the theme of transference should be left untouched.* One must wait until the transference, which is the most delicate of all procedures, has become a resistance.

It is therefore only after the transference resistance has been removed by making it conscious, that the analyst, from whom these unconscious components of the transference are now detached, can, like the priest, bear witness to all that the patient has to confess/remember.

In this sense, by virtue of the analyst's abstinence, the aims of classical analysis in lifting repressions, filling gaps in memory and making the unconscious conscious are most

likely achieved. The analyst manages the transference by maintaining technical neutrality and by keeping his/her countertransference in check.

In as much as Freud (1917a) argues that if there are no repressions to lift then psychoanalysis has nothing to offer. By the same token, if there is no capacity within the patient to witness such revelations then there is nothing upon which the success of psychoanalytic technique can rest.

Similarly, by implication, if there is no will to love and be loved back in return, then there can be no will to recover. For, without a conscious expectation for cure, there is nothing the classical analyst can offer his/her patient in the way of bringing what is unconscious under conscious control.

By the same token, however, without the analyst's neutrality, or ability to keep his/her countertransference in check (including the wish to cure the patient) there is no means by which the unconscious conflict modelled on an earlier one can be revived, fought out in the room and rendered amenable to consciousness. In other words, in the absence of the analyst's technical neutrality there can be no means of rendering a cure by love under any other circumstances into one by talking instead.

From this, it seems clear that while the transference, in all its aspects, is central to psychoanalysis, so is the analyst's capacity for maintaining technical neutrality by keeping his/her emotional attachment (countertransference) to the patient in check.

2.5 Freud - On the question of analysability.

Technically, analysability depends on the patient's capacity for transference – that is, in its broadest sense, a capacity for establishing and maintaining an emotional tie to the figure of the analyst. In addition to the patient's capacity for transference, the other technical conditions for analysability rest with the analyst. These conditions include the analyst's training, experience and expertise in the practice of psychoanalysis. The patient's analysability also requires of the analyst that he/she keep the countertransference in check and conduct the process of analysis in what Freud (1915a) referred to as 'abstinence'.

The reason why analysability for Freud centres on the patient's capacity for transference seems best answered by reviewing his views on the difference between neurosis and psychosis. In this regard, particular emphasis is placed on how Freud (1917a) accounted for why psychotic patients or those suffering from what he referred to as the narcissistic neuroses are not amenable to treatment by psychoanalysis.

Freud (1917c) limited psychoanalysis to the treatment of the class of mental disturbances he called the '*transference neuroses'* comprising anxiety hysteria, conversion hysteria and obsessional neurosis. He claims to have neglected the psychoanalytic study and hence also the treatment of other kinds of neuroses because of the "impossibility of therapeutic influence" among them (1917c**)**

Writing about what he classified as the narcissistic neuroses in contradistinction to the transference neuroses, Freud (1917a, p. 438) argued that,

> …and yet we do not succeed in lifting a single resistance or getting rid of a single repression. These patients, paranoiacs, melancholics, sufferers from dementia praecox, remain on the whole unaffected and proof against psychoanalytic therapy**.**

In fact, throughout Freud's life, he remained pessimistic about the psychoanalytic treatment of psychotic patients because of their failure to produce transference. According to Freud (1917a, p. 447**)** for example,

> Observation shows that sufferers from narcissistic neuroses have no capacity for transference or only insufficient residues of it. They reject the doctor, not with hostility but with indifference. For that reason they cannot be influenced by him either; what he says leaves them cold, makes no impression on them; consequently the mechanism of cure which we carry through with other people – the revival of the pathogenic conflict and the overcoming of the resistance due to repression – cannot be operated with them. They remain as they are…we cannot alter this in any way.

The psychotic patient's failure to produce transference according to Freud appears suggestive of incapacity to establish and maintain an emotional tie to the analyst. That is, an emotional tie either in the form of what Freud (1913) referred to as the mild positive transference or the positive erotic and negative hostile transference (the transference neuroses).

As mentioned before, the mild positive or unobjectionable transference – reasonable rapport (Freud, 1913, p. 139; Strachey, 1934) is essential to analysis because it is the aspect of the patient's relation to the analyst that imbues the analyst with influence in motivating the patient to overcome his/her resistance to the process of uncovering repressed unconscious material. Without the mild positive transference, or working alliance, the analyst is left without the kind of technical influence necessary in facilitating the process of making the unconscious conscious.

The positive erotic and negative hostile transference (the transference neuroses) on the other hand are also essential to analysis because while they serve the patient's interests in resisting the aims of analysis, they are at once also the manifestations in the room of the very repressed unconscious material the analyst attempts uncovering and as such, also represent the very symptoms the analyst attempts treating. In short, the positive erotic and negative hostile transferences are royal roads to the unconscious and therefore key psychoanalytic tools.

Since both forms of transference are essential to the practice of psychoanalysis, the psychotic patient's failure or incapacity to produce transference or insufficient residues of it means that for Freud these kinds of patients are not suitable candidates for analysis.

By contrast to the neurotic patient whose tendency to transference onto the figure of the analyst stems from an excess of unattached libido striving for satisfaction, the psychotic patient's incapacity for forming transference onto the figure of the analyst stems from a withdrawal of libido from external reality and the objects in it (Freud, 1914a; 1917d).

A key difference for Freud (1924) between neurotic and psychotic mental illness and why the former is amenable to analysis and the latter is not, lies in the degree to which the libido is withdrawn from objects. While there is a turning away from reality in both kinds of mental disturbance, the neurotic patient retains an erotic relation to people and things in phantasy, whereas the psychotic patient does not. According to Freud (1914c), the sufferer from narcissistic neurosis has "withdrawn his libido from people and things in the external world, **without** replacing them by others in phantasy" (p.66**).**

It follows from the above that the absence of a tendency to transference observed among psychotic patients and hence their unsuitability for psychoanalytic treatment is for Freud, attributable to their libido's withdrawal from external reality and regression to a state of narcissism.

Narcissism for Freud is a stage in the development of the subject's libido that precedes object choice. Instead of being directed to external objects from which to derive satisfaction, the libido is said to be auto-erotic – that is, directed to the subject's own body. Freud called this way of deriving satisfaction narcissism (Freud, 1915b, p. 134).

Narcissism for Freud is an 'objectless' state in the sense that from the **subject's perspective**, the object coincides with the ego (Brill, 1944, p. 141**)**. Libidinal object cathexes have not as yet taken place during narcissism because as Freud (1915b, p. 135) explains in *Instincts and their Vicissitudes*, "the ego-subject coincides with what is

pleasurable and the external world including objects with what is indifferent". Everything, including objects, experienced as sources of pleasure are 'introjected' or taken into the subject's ego, and similarly, everything experienced as sources of unpleasure are expelled by means of the mechanism of projection.

According to Freud (1915b, p. 136) for example, during narcissism,

> for the pleasure-ego, the external world is divided into a part that is pleasurable, which it has incorporated into itself, and a remainder that is extraneous to it. It has separated off a part of its own self, which it projects into the external world and feels as hostile.

In contrast to neurotic illness where the libido strives towards objects in search of satisfaction, in psychotic illness, the libido has become narcissistic and cannot find its way back to objects. The external world and objects in it are not cathected with interest. It is for this reason that Freud argues that sufferers from the narcissistic neuroses are not capable of transference and therefore cannot be influenced by the doctor. Analysis is not possible with these kinds of patients because their libido is directed towards and attached to their egos and not to external objects. Psychotic patients are not capable of libidinal object cathexes, the basis of transference or an emotional attachment to an object.

For Freud, analysability depends on the patient's capacity for libidinal object cathexes, the basis for forming transference. Suitability for psychoanalytic treatment in other words depends on the patient's capacity to form an emotional attachment to the figure of the analyst. As we learn from Freud (1915b, p. 137),

> …the attitudes [or emotions] of love and hate cannot be made use of for the relations of instincts to their objects, but are reserved for the relations of the total ego to objects**.**

By implication, a capacity for transference (an emotional attachment to an object) and hence analysability for Freud presupposes relatively intact ego functioning, at least in the sense of separate or what might be referred to as whole object relating. This in turn

appears to be based on what Freud (1915b, p. 136) described as the “synthesis of all the component instincts of sexuality under the primacy of the genitals and in the service of the reproductive function”.

For this reason, Freud excluded from psychoanalytic treatment sufferers from the narcissistic neuroses, whose illness involved a regression to a period prior to total ego functioning and separate object relating, and children, who’s libidinal development excluded the possibility of talking about the emotional relations (love and hate) of the total ego to objects in the external world. In other words, among patients who had not as yet developed integrated ego functioning and whole object relating, psychoanalysis was ruled out as a viable treatment option.

Psychoanalysis for Freud is limited to the treatment of neurotic mental disturbance in which the conflict to be resolved is that between sexuality and the demands of reality. Structurally speaking, that is - between the agencies of the id and ego.

Neurotic illness does not involve a conflict between the ego (internal reality) and external reality as it does among psychotic patients and infants who are still learning to discern the antithesis ego-subject and external reality and have not yet acquired a capacity for subject-object differentiation or whole object relating.

2.6 Melanie Klein - On the question of analysability

By contrast to Freud, who excluded psychotic patients and children from treatment by psychoanalysis, Melanie Klein (1926; 1955) did not. In fact, the basis of her practice and theory of development derived from her clinical observations of psychotic and in particular, child patients in analysis.

Unlike Freud (1924) who did not believe that psychotic patients and children were capable of forming transference, Melanie Klein did. For her both psychotic patients and children were capable of transference and in her view were therefore considered suitable candidates for treatment by psychoanalysis.

Close reading of Klein's (1952) work however, shows that her views on transference are quite different from Freud's. Her notions of psychopathology also deviate from Freud's classical ideas, as do the aims and methods of her treatment.

Since all these factors have a bearing on analysability, Melanie Klein's ideas about a patient's suitability for psychoanalytic treatment seem best illustrated by reviewing how her conceptualisation of the origin and nature of transference, notions about psychopathology, aims and methods of psychoanalytic treatment differ from Freud's. It is in this work that Freud's (1917a) claim that psychotic patients are not capable of transference and Melanie Klein's claim that they are, become further clarified in terms of their respective theories of development and the beginning of object relations.

While both Freud and Klein rooted the origins of transference in object relations – "they are the stuff of the transference" (Joseph, 1989, p. 203) – their respective theories of object relations, and hence also transference differ. For Klein (1952) object relations are present from the start of life. Unlike Freud (1915b) who theorized developmental stages from primary narcissism through secondary narcissism to object-choice, where object relations are a developmental milestone, Klein (1952) theorized the presence of object

relations which she categorized into ‘positions’ named and characterized by two particular types of anxiety, paranoid schizoid and depressive, from the start of life.

For Klein psychological development and relations to objects do not involve a progression through a series of stages, but rather an oscillation between what she called the paranoid schizoid position and the depressive position (Mitchell, 1986).

By contrast to Freud (1917,e) for whom psychopathology commonly involves a regression to a more primitive developmental stage, psychopathology for Klein (1946) involves instead a predominance of functioning in the paranoid schizoid position. Psychosis for example does not involve for Klein as it does for Freud, a regression to a narcissistic stage of development and narcissism in turn is also not in Klein’s view a developmental stage that precludes relations with objects. Psychotic patients for Klein (1946) function in the paranoid schizoid position where splitting mechanisms and part object relating predominate.

In so far as Klein’s (1952) psychotic patients are capable of object relations, all be they split and paranoid, they are also capable of transference. It is for this reason that by contrast to Freud’s psychotic patients who are unanalysable because they are capable of neither object relations nor transference, Klein’s psychotic patients are deemed suitable candidates for psychoanalysis.

Another key difference between Freud and Klein that appears to have a bearing on their different conceptualizations of object relations, transference and hence analysability, is that while Freud (1917d) focused on tracing the development and location of the patient’s libido, Klein focused on understanding the nature of anxiety and the role of defence mechanisms in structuring the ego and its relations to objects (Stein, 1990). In other words, whereas object relations, and hence transference, are essentially libidinal phenomena for Freud, for Klein, they are understood and conceptualized in terms of anxiety (Stein, 1990).

According to Freud (1915b) for example, libido is directed towards objects for instinctual satisfaction from the start of life. It is, however, only much later on, in the phallic-oedipal stage of development, when libido is directed towards objects *outside* the subject's own body that one can plausibly speak about object relations.

Transference and hence analysability for Freud depend on the patient's level of developmental functioning and, in particular, upon the attainment of subject-object differentiation and what Klein would call whole object relating. Object relations in Freud's view can only be whole and separate. As such, psychopathology arising from regression to a stage that precludes relations with objects external to the subject's own body, that is prior to phallic-oedipal developmental functioning (i.e., narcissism), is not classically considered amenable to psychoanalytic treatment.

In Klein's (1952) view, by contrast, anxiety and the implementation of defence mechanisms against the experience of anxiety occur in relation to objects from the start of post-natal life. Unlike Freud, for whom object relating itself is a developmental milestone, object relations according to Klein are present from the very beginning. Transference for Klein and hence analysability, therefore, do not depend on the patient's level of developmental functioning or the attainment of subject-object differentiation. For Klein, relations to part-objects are still considered object relations.

In her paper on *The Origins of Transference*, Klein (1952) explains that the **defence** mechanisms employed against the experience of anxiety are the ones that from the start of post-natal life establish object relations. These are the defence mechanisms that according to her also shape and structure the nature of transference.

In describing the origins of object relations, Klein (1952, p. 203) writes for example that,

> The primal processes of projection and introjection, being inextricably linked with the infant's emotions and anxieties, initiate object relations, i.e. deflecting libido and aggression on to the mother's breast, the basis for object relations is established; by introjecting the object, first of all the breast, relations to internal objects come into being.

In terms of her understanding of object relations, Klein (1952, p. 203) explains further that,

> My use of the term 'object relations' is based on my contention that the infant has from the beginning of post-natal life a relation to the mother (although focusing primarily on her breast) which is imbued with the fundamental elements of an object relation, i.e. love, hatred, phantasies, anxieties and defences.

For Klein the infant begins life with a fear of persecution. This is according to her the first form of anxiety and arises from the workings of the death drive. In this regard, Klein, (1952, p. 202) writes that,

> From the beginning of post-natal life destructive impulses against the object stir up fear of retaliation. These persecutory feelings from inner sources are intensified by painful external experiences, for, from the earliest days onwards, frustration and discomfort arouse in the infant the feeling that hostile forces are attacking him. Therefore the sensations experienced by the infant at birth and the difficulties of adapting himself to entirely new conditions give rise to persecutory anxiety.

In other words, for the infant, frustration is experienced as an attack by a hostile object. Similarly, the infant experiences satisfaction as being loved and cared for by a good object. According to Klein (1952) physiological experiences or 'forces' as she calls them seem to be conceived of by the infant as objects, either satisfying and good or frustrating and bad.

Thus, on the basis of physiological experiences, the infant directs feelings of gratification and love towards the satisfying and therefore 'good' breast and destructive impulses and feelings of persecution towards the frustrating and therefore 'bad' breast. Without conscious awareness the infant splits the object into a good part and a bad part. The good part is then related to as an all-good object, which the infant idealizes and tries to keep separate from the bad part, which is related to as an all-bad object towards whom the infant directs feelings of hatred and impulses of destruction. It is in relation to this all bad object, which the infant hates and wants to destroy, that it fears retaliation and experiences persecutory anxiety.

From the infant's perspective, it is not aware that the all-good object and the all-bad object are objectively speaking merely parts of the same object. It is also not aware for example that the bad object from whom it fears persecution is a projection of its own destructive impulses – a product therefore of its own aggressivity.

In other words, while the infant subjectively seems to experience bad objects as separate from its self, objectively speaking it is relating to a split off and projected part of itself. For Klein (1952), 'bad' objects are therefore not real external figures, but phantasy internal ones. They are the ones around which phantasies of paranoia are woven and schizoid defences mounted. They are also the ones that characterize functioning in the paranoid schizoid position where as a result of splitting and projecting, the discrepancy between internal and external, phantasy and real objects are greatest.

In Klein's (1952) view, so long as the infant splits the object into a good and a bad part which it loves and hates respectively, it also splits its ego and is capable only of what Klein (1952) referred to as part object relating. From an emotional point of view, the infant is not yet capable of loving and hating the same object. It cannot tolerate feelings of ambivalence while functioning in the paranoid schizoid position.

Thus, while a capacity for object relating is present from the start of life, integrated ego functioning and whole objecting relating in which feelings of ambivalence are tolerated are not. These capacities are developmental milestones. They represent functioning in what Klein (1952) referred to as the depressive position where the correspondence between internal and external, phantasy and real objects are greatest. It is towards the development of these capacities that psychoanalysis for Klein is aimed.

In other words, for Klein, the aims of psychoanalytic treatment involve shifting the patient's functioning from the paranoid schizoid position to the depressive position. Split ego functioning and part object relating must become integrated and whole. Anxiety needs to be ameliorated. Destructive impulses need to give way to reparative ones.

Feelings of hatred and destruction directed toward the object perceived as 'bad' need to be integrated and owned as the subject's own so that the fear of retaliation and persecutory anxiety can become depressive rather and the discrepancy between internal and external, phantasy and real objects shrunk.

In short, Kleinian analysis seems to be primarily concerned with treating paranoid schizoid psychopathology or what Bion (1957) and others have referred to as the psychotic parts of the patient's personality (Rosenfeld, 1987)**.** The very kinds of patients that Freud (1917a,b) deemed unsuitable candidates for psychoanalysis, Klein (1952) focused her attention on understanding and treating.

On the basis of Klein's differing views on the origins and nature of object relations, psychopathology, aims and methods of treatment as well as the kinds of patients included in analysis, it follows that her views on the nature, role and management of transference in the psychoanalytic setting also differ markedly from Freud's. Since these differences have important implications for the question of analysability, their inclusion warrants review.

By contrast to Freud (1915b) for whom object relations and hence a **capacity** for transference come into being as a result of libidinal strivings towards objects outside the subject's own body (external objects/whole objects) for satisfaction and in service of the reproductive function, for Klein (1952) object relations and hence transference come into being as a result of defence mechanisms employed against the experience of anxiety from the start of post natal life.

For Freud (1917e) the transference arises from an excess of unattached libido, which in search of satisfaction from objects in the real world, becomes displaced from the original Oedipal objects onto the figure of the analyst.

By contrast, the transference for Klein as Hinshelwood (1994, p. 234) puts it,

> …is generated from the present use of historical defences; in other words the adult personality's unconscious phantasies (which underlie all these defence mechanisms) is transferred from the present unconscious into the analytic relationship.

Given Klein's focus on anxiety in determining the origin and nature of object relations, the transference for her does not involve a displacement of libidinal strivings for satisfaction from whole oedipal objects in early childhood onto the figure of the analyst in the present. For Klein, the patient neither repeats in his/her relation to the figure of the analyst (in the transference) an infantile incestuous wish for love nor manifests an erotic attachment to the figure of the analyst in the room.

Also, unlike Freud (1912a) for whom the analyst in the transference becomes an object by displacement of the patient's infantile incestuous wish for love, the analyst according to Klein does not. Rather, by virtue of the defence mechanisms employed against the experience of anxiety, in particular those of splitting and projecting, the analyst in the transference for Klein (1952) becomes an object of the patient's projections – a part object.

Thus, instead of representing the Oedipal figure – a whole object, the analyst in Kleinian analysis represents an externalization of the patient's phantasy, internal object world, which in essence is a repudiated part of the patient – a part object.

In the paranoid schizoid position for example, the wish to destroy is not in fact the analyst's, but the patient's and the fear of retaliation is paranoid because it is a product of the patient's own aggressivity projected into, and hence attributed to, the figure of the analyst.

By contrast to Freud (1915a) for whom the analyst in the transference is therefore most commonly a loved whole object or an object of the patient's desire, for Klein (1952; 1955) the analyst in the transference is most commonly a hated and feared part-object.
It is interesting to note here that whereas Freud (1915a) tended to focus primarily on the love in transference, Klein's (1952) focus centered on the nature of anxiety and corresponding negative transference. In this regard Klein, (1952, p. 207) argued that,

> I became convinced that the analysis of the negative transference, which had received relatively little attention in psychoanalytic technique, is a precondition for analyzing the deeper lays of the mind.

Given the differences between Freud and Klein in terms of the origin and nature of object relations and based on the different kinds of patients each treated in analysis, there are also differences between Freud and Klein on how the transference tends to manifest in the room both at the start of and during the analytic process.

Unlike Freud who mainly treated neurotic adult patients who often started the analytic process with a conscious expectation for cure from the analyst (i.e., mild positive transference) which during the course of treatment intensified into an unconscious expectation for love from the analyst (transference neurosis), Klein, who mainly treated child and psychotic patients noticed how analysis was often started with feelings of acute anxiety in relation to both the situation and herself.

However, rather than regard this as a realistic reaction to be expected from any person placed in an unusual setting with a stranger, Klein construed her patients' anxious reactions as irrational ones (i.e. based on phantasy), in other words, as transference ones.

In view of Klein's underlying theory on the origins of object relations, she regarded the patient's anxiety as a direct derivative of the death drive and a manifestation of the negative transference. According to Klein, the patient's anxiety and transference did not arise from anything pertaining to the real figure of the analyst, but stemmed directly from

the patient's aggressive impulses that she believed to be innate and arising from the death instinct (Stein, 1990).

By tracing the patient's anxiety to unconscious phantasies of destruction directed towards objects of which she was assumed symbolic, Klein's notion of transference (specifically the negative transference) emerged as a product of the patient's aggressive impulses split off, projected into and hence attributed to the figure of the analyst.

Unlike Freud (1913, 1917a), who distinguished the reasonable rapport from the transference neurosis, or types of transference in terms of those arising from a conscious expectation for cure and those arising from an unconscious expectation for love, Melanie Klein (1952, p. 209) referred to *total situations*. Also rather than limiting her understanding of transference to "direct references to the analyst in the patient's material**", she** included "the whole material presented … [from which]…the '*unconscious elements'* of the transference are deduced" (Klein, 1952, p. 207).

In other words whereas the transference for Freud represented a direct or explicit manifestation of the unconscious, for Klein the unconscious phantasies underlying the patient's relation to her were deduced from all the material that the patient brought into the analytic/transference situation.

Applying what Klein had learnt from her play technique with children to the analysis of adult patients, Klein (1952, p. 209) argued for example that,

> For instance, reports of patients about their everyday life, relations and activities not only give an insight into the functioning of the ego, but also reveal – if we explore their unconscious content – the defences against the anxieties stirred up in the transference situation.

Thus, for Klein with *all* patients, children and adults alike, everything in the room (i.e., in the transference situation) was *assumed* to relate to the transference (i.e., the patient's relation to the analyst). For this reason all aspects of the patient's behaviour, both verbal

and non-verbal, implicit and explicit were regarded by Klein as important clinical data to analyze, deduce the unconscious elements and interpret.

Whereas Freud (1912a), like Klein recognized the ubiquity of transference, unlike Klein, he emphasized the importance of discerning the unobjectionable mild positive transference (in the form of the reasonable rapport) from the erotic or hostile transference - the transference neurosis in the analytic situation.

According to Freud (1912a), since not all aspects of the patient's relation to the analyst arise from the unconscious or function as a resistance to the process, not all aspects of the patient's relation to the analyst are necessary to analyze and interpret.

In the absence of explicit evidence of transference most commonly manifesting in the form of an expectation for love from the figure of the analyst and functioning as a resistance to the process of remembering, Freud (1913) advised clinicians to leave this most delicate of procedures alone.

Freud appears to have based this advice to clinicians on his observation that while the transference is present in the patient from the beginning of the treatment, in its unobjectionable mild positive form, it actually serves the interests of the analysis and should therefore not be interpreted away. As he explains in L*ecture 27 of his Introductory Lectures on Psychoanalysis, (*Freud, 1917a, p.495)**,**

> …a transference is present in the patient from the beginning of the treatment and for a while is the most powerful motive in its advance. We see no trace of it and need not bother about it so long as it operates in favour of the joint work of analysis.

By contrast to Freud (1913; 1917a) who only interpreted the transference resistance (transference neurosis) in effect to remove it as a source of resistance, to fill in the gaps left in the patient's memory and to restore the patient's experience and perception of the analyst as a real figure, Klein (1952) interpreted all aspects of the transference, both

positive and negative in order to change the patient's split experience and perception of her as either all good or all bad.

Based on the distinction between Freudian and Kleinian psychoanalytic practice, it seems plausible to argue, that in so far as the Kleinian analyst works in the transference all the time for the purpose of restoring splits, integrating good and bad, love and hate, of shrinking the disparity between phantasy and reality and fostering whole rather than part object relating – of shifting paranoid schizoid functioning to depressive position functioning in other words, a capacity for whole object relating is a milestone, a therapeutic goal in Kleinian analysis and not, as it is in Freudian analysis, a prerequisite for analysability.

By extending the definition of transference to include all aspects of the patient's relation to the analyst, Kleinian analysts claim strict adherence to the Freudian principle of analyzing and interpreting the transference, even among patients classically considered incapable of transference and therefore regarded as unsuitable candidates for psychoanalysis.

Thus, despite differences in conceptualization, handling and management, transference in Kleinian analysis retains its status as a royal road to the patient's unconscious and as a central analytic tool in effecting intrapsychic change. The technical differences between the practice of Freudian and Kleinian psychoanalysis that are highlighted in this review often seem concealed behind a common emphasis on transference analysis and interpretation as the primary vehicle in effecting change.

By contrast to Klein (1952), however, who emphasized the importance of transference analysis and interpretation across all kinds of patients irrespective of their developmental status or psychopathology, including the kinds of patients in analysis whom Freud (1917a) would have excluded because of their failure to produce transference, Winnicott (1954c, p. 278) emphasized the importance of classifying patients "according to the technical equipment they require of the analyst**".**

Winnicott (1955) neither advocated the same technique across all kinds of patients irrespective of their developmental functioning or psychopathology, nor limited analysability to a patient's capacity to form transference of the kind that Freud described.

Rather, Winnicott **(**1955**)** classified or grouped patients, on the basis of the nature of their object relating capacities and ego functioning, into those eligible for treatment by classical psychoanalytic technique as originally described by Freud and those requiring a modification of Freud's classical psychoanalytic technique.

It is to a review of Winnicott's ideas on analysability that the review now turns.

2.7 Winnicott - On the question of analysability.

Like Klein (1952), Winnicott (1955) treated children and psychotic patients psychoanalytically. For Winnicott, a patient's suitability for psychoanalytic treatment did not depend on a patient's capacity for transference of the kind that Freud (1912a) described.

Winnicott (1955) was cognizant of the fact, for example, that not all patients, children and psychotics notwithstanding, are capable of intact ego functioning and real, separate or what Klein would call whole object relating. Not all patients for Winnicott are therefore necessarily capable of forming the kind of relationship to the analyst upon which the success of classical Freudian analysis depends, or of defending against the experience of anxiety arising out of instinct by displacing repressed unconscious Oedipal strivings onto the figure of the analyst.

Not all patients, according to Winnicott, are capable of forming either a real relationship or working alliance (as it is called today) or the kind of attachment to the figure of the analyst that represents a return of repressed unconscious material – a transformation of neurotic illness into a present day transference neurosis. According to Winnicott (1955)

it cannot be assumed that all patients included in analysis have received the kind of good enough maternal care that allowed for the development of an intact ego capable of object relating to whole persons in the world. It cannot be assumed that all patients are therefore automatically suitable for treatment by classical psychoanalysis.

In writing about his work with children, borderline and psychotic patients, Winnicott **(**1955, p. 296) argues that,

> this work widens the concept of transference since at the time of the analysis of these phases the ego of the patient cannot be assumed as an established entity, and there can be no transference neurosis for which, surely, there must be an ego, and indeed an intact ego, an ego that is able to maintain defences against anxiety arising out of instinct, the responsibility for which is accepted.

In a number of works and most notably in his paper entitled "the clinical varieties of transference", Winnicott (1955; 1954) alludes to the idea that the transference manifests differently depending on where along the developmental continuum the patient is functioning and particularly on the status of the patient's ego.

Among patients for example who do not demonstrate intact ego functioning and a capacity for whole object relating, Winnicott (1955, p. 297) notes that, "one characteristic of the transference at this stage is the way in which we must allow the patient's past to *be* the present". He argues further that,

> Whereas in the transference neurosis the past comes into the consulting room, in this work it is more true to say that the present goes back into the past, and *is* the past. Thus the analyst finds himself confronted with the patient's primary process in the setting in which it had its original validity.

In other words, the transference among the kinds of patients Winnicott (1955) describes recalls the earliest infant-mother relationship prior to subject object differentiation rather than the libidinal strivings directed towards Oedipal objects (which are whole objects) from whom the child has already separated. The transference in Winnicott's work does

not involve repressed unconscious material of a forgotten past repeated in the present in the form of the neurotic symptom.

Rather than exclude these kinds of patients from psychoanalytic treatment because they do not produce the 'right' kind of transference for conducting a classical analysis, Winnicott (1955) argued for the inclusion of patients where intact ego functioning and whole object relating cannot be assumed in analysis by modifying classical psychoanalytic technique.

In working with patients considered unsuitable candidates for classical psychoanalysis, Winnicott (1955, p. 297) advocated a different kind of work but one that can still be called psychoanalytic because the analyst still "follows the basic principle of psychoanalysis, that the patient's unconscious leads and is alone to be pursued".

In this regard, there appears to be a distinction in the nature of the unconscious that is to be pursued. Whereas for Freud (1912a; 1917b) the analyst in classical psychoanalysis pursues repressed unconscious material, for Winnicott (1955), as for Klein (1952), the analyst pursues split off and projected unconscious material.

According to Winnicott, (1962), split off unconscious material has not been integrated and as a result has not yet been experienced by the patient's ego. So called split off unconscious material for Winnicott exists alongside of the ego rather than in place of it.

It is therefore in the pursuance of split off unconscious material - that is, the material that the patient has not yet integrated or experienced and that therefore exists alongside of ego functioning that Winnicott (1955) advocated a different kind of work than that of classical psychoanalysis.

In this regard and based on his work with patients who had not achieved intact integrated ego functioning, whole or separate object relating, or what he referred to as a 'true' self,

Winnicott (1955, p. 297) identified the importance of the psychoanalytic 'setting' and the management of this setting over and above interpretive work. He writes,

> Where there is an intact ego and the analyst can take for granted these earliest details of infant care, then the setting of the analysis is unimportant relative to the interpretative work…[however]…in the work that I am describing the setting becomes more important than the interpretation. The emphasis is changed from one to the other.

By shifting emphasis from the importance of interpretation to that of the analytic setting or environment, psychoanalysis/analysability for Winnicott (1955) could be extended to include the analysis of those phases of development prior to intact ego functioning and whole, separate, real or authentic object relating.

Accordingly, in Winnicott's (1955) work with borderline patients in analysis, he was primarily concerned with the analysis and treatment of patients who, in his view, had not achieved what he referred to as integrated ego functioning – that is an ego capable of experiencing and mastering id impulses, of discerning the difference between subjective conception and objective perception; 'me' and 'not me', what is inside from what is outside, fantasy from reality.

In short, Winnicott (1962) was concerned with treating patients who according to his developmental model had not been able to successfully negotiate development from absolute dependence, through relative dependence towards independence.

Since the successful development through these phases and the attainment of all the capacities described above depend on what he referred to as good enough maternal adaptation to need, it stands to reason that Winnicott (1960) modeled his ideas on psychopathology in terms of deficits in the provision of good enough maternal adaptation to need during the very earliest stages of development.

In this regard Winnicott (1960) formulated his notion of a 'false-self,' which develops in response to maternal adaptation to need that is not good enough during the very earliest stages of the infant-mother relationship – or during the "holding" stage of maternal care.

In his analysis of deeply regressed borderline and psychotic patients, Winnicott (1960) traced the origins and aetiology of a false-self to the stage of first object-relations. That is, the stage prior to the ego's organization of defences against id impulses and during the stage of the infant's absolute dependence on maternal care.

It is in relation to an object that is not able to provide good enough adaptation to need and at a time of absolute dependence on this object, that the infant develops distorted ego functioning and hence also a distorted capacity for object relating in the form of a 'false' self.

The pathology that belongs to the functioning of a 'false' self does not involve the individual in integrated ego functioning or authentic object relating. It is the kind of pathology that while presenting with a show of being real is actually a defensive structure that hides and protects what Winnicott (1960, p. 142) has called the "true" self from the threat of annihilation.

While the false-self wards off environmental impingement by complying with the demands of external reality, the true-self which is the patient's inherited potential remains locked in a state of pathological isolation, denied the opportunity of development and withdrawn from contact with external reality and the objects in it (Winnicott, 1960).

It is therefore not the patient's true-self that comes for fixing or that is even accessible to psychoanalysis, but the patient's false-self. As Winnicott (1956; 1960) explains, in addition to its defensive function of protecting and hiding the true-self from annihilation, the false-self also has as one of its main features the search for the conditions in which the true-self might begin to exist. It is with the unconscious hope of having these

conditions provided that the false-self enters the analytic situation requiring of the analyst the provision of good enough adaptation rather than interpretation.

It is in providing these conditions that psychoanalysis according to Winnicott (1955) involves a modification of classical psychoanalytic technique from an emphasis on interpretation to management of the setting and by implication a shift in the role of the classical psychoanalyst from “blank screen” to one modeled on the “good-enough mother”.

Thus, by contrast to the classical psychoanalyst who fills gaps in the patient’s memory with interpretations, in the work that Winnicott (1954c) describes, the analyst fills gaps in the patient’s development left by deficits in the provision of environmental care by assuming the role of the good enough mother and in providing adaptation to need that can be called good enough – at least in token form.

The treatment of mental disturbance, arising from environmental failure during the earliest stages of the mother-infant relationship and resulting in the development of a false-self defence involves for Winnicott (1954a; 1955; 1960) a shift in the aims of classical psychoanalysis from interpreting the transference to remove it as a source of resistance to the process of remembering, to managing the setting to relieve the false-self of its defensive function and to release the true-self from a state of environmentally impoverished isolation.

According to Winnicott (1954a; 1954c), it is in managing the setting that the analyst establishes the conditions in which the false-self feels safe to hand itself over and relinquish its task of ‘holding’ the true-self to the analyst.

In providing good enough adaptation to need, the analyst in other words creates the kind of setting that invites regression to early dependence and in so doing gains access to the true-self otherwise isolated and withdrawn from contact with external reality and the objects in it. (Winnicott, 1954a; 1955)

Unlike the classical psychoanalyst therefore who interprets the transference to transform the patient's repeating of the past in the present to remembering it, the analyst in the transference situation that Winnicott (1955, 297) describes, allows the patient's "present to go back into the past and become the past" to transform pathological withdrawal and defensive splitting into an organized regression to dependence (Winnicott, 1954a, p. 257)

According to Winnicott, (1954c, 286**)**

> The setting of analysis reproduces the early and earliest mothering techniques. It invites regression by reason of its reliability. The regression of a patient is an organized return to early dependence or double dependence. The patient and the setting merge into the original success situation of primary narcissism.

With the analyst 'holding' the true-self, opportunity is provided for starting afresh and for "displace[ing] the original environmental-failure situation" (Winnicott, 1954c, p. 281). By "unfreezing the original failure situation", the true-self can come into being for the first time with the provision of adequate though belated adaptation.

As Winnicott (1954c, p. 286) writes further in this regard,

> Progress from primary narcissism starts anew with the true-self able to meet environmental failure situations without organization of the defences that involve a false-self protecting the true-self.

With the patient deeply regressed and in a vulnerable state of dependence, the aim of analysis under these circumstances involves the provision of the kind of conditions which facilitate true ego development and the building up of sufficient ego strength to recall the original failure situation and to experience and express anger for the first time rather than withdraw and feel futile (Winnicott, 1955).

To this end, the analyst meets the deeply regressed patient's dependency needs with good enough adaptation rather than frustrate them with interpretations and in so doing allows

the patient's ego, emerging from a state of isolation, to gain strength by experiencing for the first time, id impulses as part of the self (Winnicott, 1960b).

By providing good enough adaptation, the analyst allows the patient to experience for the first time, external reality and objects in it as subjectively conceived. Like the good enough mother, in meeting the patient's ego needs the good enough analyst brings the environment to the patient in a way that that allows for the first time the patient to experience external reality and the objects in it as part of the self – as projections in other words.

In meeting the patient's spontaneous gesture, which is the potential of the true-self, the analyst gives the patient the illusion of primary creativity and omnipotence so that id satisfactions can become ego strengtheners (Winnicott, 1960b).

By satisfying the patient's ego needs, the analyst builds the patient's ego strength. It is according to Winnicott (1955, p. 287) that "from this new position of ego strength…[the patient can experience]…anger related to early environmental failure, felt in the present and expressed".

Failure on the part of the analyst to meet the deeply regressed patient's needs at a point prior to the true ego's coming into being and gaining strength, results according to Winnicott, "not in anger but in a reproduction of the environmental situation which stopped the processes of growth…[with the result that]…[t]he individual's capacity to wish has become interfered with and we witness the reappearance of the original cause of a sense of futility". (Winnicott, 1954c, p. 288).

Failure at a time prior to the true ego establishing contact with external reality and objects in it as subjectively conceived and omnipotently controlled results not according to Winnicott (1954c) in frustration or anger at frustration but in the experience of the threat of annihilation against which the false-self mounts its defence and leaves as a

consequence the true-self once again in a state of pathological isolation - withdrawn from contact with external reality and the objects in it.

Winnicott (1954c) suggests that while the patient is in a deeply regressed state, the analyst sensitive to the patient's ego needs must be careful not to fail prematurely or in a way that is beyond the patient's capacity to tolerate. That is, prior to the patient's ego having built up enough strength to experience anger in relation to the frustration that adaptive failure at this time would imply.

In other words adaptive failure prior to the patient's establishing and experiencing external reality and objects as subjectively conceived and omnipotently controlled – as part of the self - as 'me' in other words, results in a disruption of the maturational processes and a reinstatement of the false-self protecting and hiding the true-self (Winnicott, 1960a).

In so far as the aims of analysis involve for Winnicott (1955) effecting a shift in the main site of operation from a false-self to a true-self, Winnicott appears particularly concerned with the way in which a change over from the patient's experiencing disruption to experiencing anger takes place.

In this regard, it is not enough that the analyst provide good-enough adaptation where this cannot be assumed to have been a fact in the patient's earliest infant-mother relationship. While good enough adaptation in the form of ego support must be provided at a time of the patient's dependence on the analyst, it is in the further development towards independence or progress from dependence towards independence that good enough adaptation as a corrective emotional experience is on its own not enough to affect such a shift (Winnicott, 1963a).

The patient's change over from dependence towards independence, from relating to the analyst as subjectively conceived of and omnipotently controlled to relating to the analyst as objectively perceived and outside the area of omnipotence, depends according to

Winnicott not on the analyst's meeting of the patient's needs (good enough adaptation) but in allowing the patient to make use of the analyst's adaptive failures which given the constraints of the analytic situation, are inevitable. "The analyst after all is not the patient's natural mother" (Winnicott, 1955, p. 299)

In writing about the change over from experiencing disruption as a result of adaptive failure to experiencing anger, Winnicott (1955, p. 298) explains for example that,

> The clue is that the analyst's failure is being used and must be treated as a *past* failure, one that the patient can perceive and encompass, and be angry about now. The analyst needs to be able to make use of his failures in terms of their meaning for the patient, and he must if possible account for each failure even if this means a study of his unconscious countertransference.

In other words, by using the analyst's failures as an example of a past one and expressing anger about it for the first time, the patient places the analyst outside the area of omnipotence, and by the analyst surviving the patient's anger without retaliation, that is, without interpretation, the patient becomes able to recognize and accept the analyst as a real and separate figure in the world – as having been there all the time. The patient destroys the analyst in fantasy and the analyst survives in reality Winnicott, (1968).

The benefits of making the shift from dependence towards independence without disruption of the maturational processes (that is with good enough adaptation) include not only the development of a capacity to be alone, which in itself is a measure of maturity and health, but also a capacity for concern (Winnicott, 1958a; 1963b).

The patient's successful shift from dependence to independence, from relating to the analyst as a subjective conception (me) to a real and separate person in the world (not me) marks not only the patient's entry into the depressive position which according to Winnicott (1955) is an achievement of the kind of work that he describes, but the point at which the analyst's work in effecting a shift in functioning from a false-self to the true-self can be considered done.

Having acquired true independent status and a shift from relating to objects subjectively conceived to those objectively perceived, the patient is now in a position to use the analyst and, equipped with a capacity for accepting and recognizing similarity (me) and difference (not me), to benefit from the insights that transference interpretations classically imply (Winnicott, 1951; 1968).

The application of classical psychoanalysis can ensue from this point onwards as Freud originally described it and without the technical modification requiring a shift in emphasis from interpretation to management of the setting (Winnicott, 1954c).

It is therefore that by contrast to Freud who limited psychoanalysis to the treatment of the transference neuroses, Winnicott (1958b) emphasized the importance of diagnosis and classification of cases to determine not the patient's suitability for analysis but the kind of analysis required.

(It is interesting to note that while both Winnicott and Klein work to achieve functioning in the depressive position they do so by different means – Klein by working in the transference and Winnicott by managing the setting).

In so far as the psychoanalytic treatment requirements of shifting a false-self to a true-self represent a shift in classical technique from an emphasis on interpretation to management the setting, Winnicott's (1952) understanding of psychopathology, traced back to a period prior to Oedipus and requiring of the analyst assuming a role modeled on that of the good enough mother, has important implications for the nature, role and management of the transference that differ markedly from Freud and Klein's work. Since these differences also have important implications for the question of analysability, their explication from Winnicott's body of work warrants review.

For example, by contrast to Freud (1913) who in his paper entitled "*On Beginning the Treatment*" recommends a trial period of between two and three weeks in which to determine a patient's suitability for psychoanalysis and in which to establish a usable

transference - a reasonable rapport in other words, or working alliance, Winnicott (1958b; 1960a; 1963) emphasizes the importance of recognizing the presence of a false-self personality.

The importance of recognizing a false-self personality lies according to Winnicott (1960a), not so much in determining a patient's suitability for psychoanalysis per se, but in determining the **kind** of psychoanalysis to be practiced.

In so far as the false-self involves the individual in pseudo contact with external reality and the objects in it, an interesting problematic is raised in terms of what Freud (1912a) referred to as the usable transference of the neurotic patient or what is more currently called the working alliance and therefore also in the accurate classification and selection of a case considered suitable for classical psychoanalysis.

For example, by contrast to a usable transference, which involves the patient in co-operation with the rules of the analytic setting and plays an important role in determining the success of psychoanalysis as it is practiced classically among neurotic patients, the transference that belongs to the false-self is by implication a false transference.

It is suggested here that the transference that belongs to the false-self with compliance as its main feature can very easily pass and masquerade as a usable transference or working alliance. At face value, the false-self, presenting in analysis, can at first seem like neurosis and compliance like co-operation.

The analyst's failure therefore in recognizing the presence of a false-self personality and the transference that belongs to it as a defence, results not only in the patient's inclusion in the wrong kind of psychoanalysis, but in the analyst's failure to recognize and hence treat the very underlying pathological state the false-self comes to analysis for fixing – namely the true-self hidden and protected from the threat of annihilation.

In so far as the transference that belongs to the false-self is necessarily a pseudo transference (a pseudo attachment to the analyst), it seems safe to suggest that the transference that belongs to the true-self in a state of isolation, withdrawn from contact with external reality and the objects in it, is an 'absent' transference.

The absent transference that belongs to the true-self locked in a state of isolation or pathological primary narcissism represents the manifestation of the true symptom for which the false-self comes in search of fixing and that requires of the analyst management of the setting rather than transference interpretation.

While the false-self presents in analysis in the form of a pseudo attachment to the analyst with compliance as its main feature, it also carries with it the unconscious hope that conditions in which the true-self can begin to exist will be provided (Winnicott, 1960a).

By implication, there are two aspects of the transference of the false-self - an explicit aspect in the form of the patient's compliance, which is a manifestation of its defence of the true-self and an implicit part manifest in the unconscious hope for conditions in which the true-self can begin to exist.

In effecting a shift from the false-self to the true-self, the analyst removes the false-self by providing good enough adaptation to need rather than by interpreting it away. It is in meeting the implicit transference need of the false-self rather than interpreting the patient's compliance as a defence, that the analyst provides the conditions in which the false-self feels safe to hand over its function of holding the true-self to the analyst and in which an organized regression to dependence that allows access to the true-self is facilitated (Winnicott, 1954a).

By contrast to the classical analyst who frustrates the patient's wish for love and removes the transference neurosis by interpreting it, the analyst, in the work that Winnicott (1955; 1960a, b) describes, satisfies the patient's unconscious hope for conditions in which the

true-self can begin to exist and removes in effect what can be called the explicit transference of the false-self by providing good enough adaptation.

In meeting the implicit needs of the transference of the false-self the analyst removes the false-self defense and turns compliance into co-operation – the false-self hands over its function of holding the true-self to the analyst and feels safe to regress to dependence. The analyst converts pathological withdrawal into regression (Winnicott, 1954a).

Having regressed to the "success situation of primary narcissism" as Winnicott (1954c, p.286) puts it and with access to the true-self gained in this way, the analyst can now begin working, by implication, in what I am suggesting amounts to the absent transference of the true-self by providing good enough adaptation to need. With the analyst holding the true-self and not the false-self doing so, opportunity is provided for starting afresh with good enough though belated adaptation (Winnicott, 1954c).

By contrast to the classical psychoanalyst therefore who keeps his/her countertransference in check, the analyst in the work that Winnicott (1947) describes makes use of his/her countertransference to identify and empathise with the patient. In a deeply regressed state of extreme dependence on the analyst, the patient is not able to communicate his/her needs verbally. A corollary of the use of the analyst's countertransference in meeting the patient's needs empathically is to be found in the good enough mother's state of 'primary maternal preoccupation'. According to Winnicott (1956), primary maternal preoccupation is a specialized state that develops in the mother during pregnancy, lasting for a few weeks after the birth and involving her in a heightened state of identification with her infant allowing her to meet her infants needs reliably and empathically without verbal communication.

In other words, by using the countertransference to meeting the patient's dependency needs empathically, the analyst is able to 'hold' the true-self and, in providing good enough adaptation to need at this level of dependence, allow the patient to exist in a state

of undisturbed isolation from environmental impingement. That is, without awareness of external reality or objects that are separate from itself in it (Winnicott, 1960b).

It is in this state of undisturbed isolation that by virtue of the analyst's adaptation, the patient is given the illusion of primary creativity and omnipotence and can begin to experience external reality and objects as part of its own creation, as subjectively conceived. In meeting the implicit transference needs of the false-self – the unconscious hope - the analyst provides the conditions in which the patient's true-self develops a capacity for relating to the analyst-object as a subjective conception – as part of me in other words.

The transference in other words that belongs to this era of development, that is the patient's dependence on the analyst and the analyst's meeting of the patient's dependency needs, is based on the patient's relation to the analyst as a subjective conception – as a projection of itself in other words (me) and not as a separate figure objectively perceived (not me) (Winnicott, 1968).

As a satisfying object, the analyst is not yet experienced as separate from the patient and it is in this sense that the undisturbed isolation of the patient's true-self being held by the analyst echoes Freud's (1915b) primary narcissism in which state and from the patient's perspective there are no objects objectively perceived.

In meeting the implicit transference need of the false-self the analyst transforms a pathological state of isolation (primary narcissism) into a healthy state of primary narcissism and objectlessness into the illusion of objectlessness (Winnicott, 1952).

It is ironic that the patient's capacity for relating to objects subjectively conceived of is the basis for the illusion of objectlessness. For this state is not objectively speaking an objectless state. It is only objectless from the patient's perspective because the good enough analyst allows this to be so.

In meeting the implicit transference need of the false-self in other words, I am suggesting that the analyst develops within the patient a capacity for transference but not the kind of transference that requires interpreting at this stage. For interpreting the transference at the level of the patient's emerging capacity to experience objects as subjectively conceived, results not in frustration but in the threat of annihilation. The analyst must leave as unresolved the paradox that while what is good and for that matter bad in the environment is not in fact a projection, it should be allowed to be perceived as one initially (Winnicott, 1960b, p. 38).

Winnicott's (1960b) work differs from Klein's (1952) in this sense, for interpreting the patient's projections amounts to undoing the very establishing of a capacity to relate to the analyst, if at first, only as a subjective object and as such constitutes an impingement which reinstates the very state of affairs that comes to analysis for fixing in the first place.

It is in the reliability of the setting and the trust gained in the analyst who through the continued and repeated provision of good enough adaptation allows the maturational processes that lead to true ego development to unfold. It is by relating to the analyst as a subjective object that id satisfactions become ego strengtheners and that eventually allow for the patient to recall the original failure situation and to make use of the analyst's inevitable adaptive failures as an example of the past and to express anger for the first time (Winnicott, 1955).

The analyst, during this phase of repudiation of the object, that is, during the transition from relating to the analyst as a subjective object to an objective one, treats the patient's anger not as resistance or the negative transference to be interpreted away but as objective anger to be allowed. As Winnicott, (1955, p. 298) writes for example,

> In these phases of analytic work that which would be called resistance in work with neurotic patients always indicate that the *analyst has made a mistake* , or in some detail has behaved badly; in fact, the resistance remains until the analyst has found out the mistake and has tried to account for it…if he defends himself, the

> patient misses the opportunity for being angry about a past failure just where anger was becoming possible for the first time.

In other words the patient's resistance is a signal of failure on the part of the analyst in providing good enough adaptation and about which failure the analyst must assume responsibility, not by interpretation but by trying to account for it. Thus by contrast to the classical analyst who removes the patient's transference as a resistance to the process, the analyst in the work that Winnicott (1955) describes uses resistance as a signal of having failed the patient in some way.

The analyst in other words treats what otherwise would be regarded as the negative transference as objective anger and in so doing allows the patient to become angry about a past failure for the first time and make the important transition from dependence to independence, from relating to the analyst-object as a subjective conception to using the analyst-object as a real separate and whole figure in the world (Winnicott, 1955).

In terms of the transference, it seems that at the point of the patient's transition from dependence on the analyst towards independence – from relating to the analyst as a subjective conception to objectively perceived - the analyst assumes the role of a transitional object – that is as both a transference object, symbolic of the mother and as an object that is also not the actual mother (Winnicott, 1951).

For example, in allowing the patient to make use of his/her adaptive failures as an earlier failure, the analyst functions on the one hand as a transference object, as a symbol in other words of the earlier figure who did not provide adaptation that was good enough.
On the other hand, in surviving the patient's angry attacks without retaliation - that is without interpretation, the analyst allows the patient to get angry for the first time and in doing so to place the analyst outside the area of omnipotent control. It is the analyst's survival of the patient's anger, treated as objective anger and not as the negative transference that makes the analyst real and facilitates the patient's transition from relating to him/her as a transference object to a real separate figure in the world (Winnicott, 1971).

The kind of work that Winnicott (1955, p. 299) describes is “exacting”, partly because of the sensitivity required of the analyst in meeting the patient’s needs (implicit in the transference of the false-self) by providing a good enough environment/setting and partly because this kind of work requires of the analyst to look for his/her own mistakes whenever resistances appear and to use them not as material to be interpreted but as examples of adaptive failure to be accounted for.

In writing about the importance of the analyst using his mistakes, Winnicott (1955, p. 299) argues that,

> Yet it is only by using his own mistakes that he can do the most important part of the treatment in these phases, the part that enables the patient to become angry for the first time about the details of failure of adaptation that (at the time when they happened) produced disruption. It is this part of the work that frees the patient from dependence on the analyst.

By contrast to Freud (1917a) for whom analysability depends on the patient’s capacity for transference in the work that Winnicott describes analysability appears to rest with the analyst’s capacity to develop within the patient a capacity for transference, first in the form of an attachment to the analyst as a subjective object and then as a real whole and separate figure in the world. In doing so the analyst must be prepared and sensitive to the patient’s deeply regressed state and extreme dependence and exclude from analysis any patient where the possibility of providing good enough adaptation might be excluded.

Winnicott’s (1955; 1960a) conceptualization of psychopathology in terms of a false-self hiding and protecting a true-self as well as the treatment requirements of shifting a patient’s functioning from a false-self to a true-self emerge as being of central importance and relevance to this study.

Firstly, based on Winnicott’s (1960a) formulation of the false-self-true-self split, manifesting by implication in the form of a pseudo transference hiding an absent one, a post Freudian conceptualization of absent transference treatable by a therapeutic technique that can still be called psychoanalytic emerges from Winnicott’s work. .

Secondly, in so far as the psychoanalytic aims of shifting the patient's main site of functioning from a false-self to a true-self involves removing the false-self by providing conditions in which it can hand itself over, an organized regression to dependence to access the true-self, and providing the kind of setting in which the maturational processes can begin, Winnicott's (1955) work provides an answer to the research question in its original form.

Psychoanalysis involving a modification in classical technique from an emphasis on interpretation to managing the setting therefore not only answers the research question in its original form, but also acts as a theoretical model on how psychoanalysis might be practiced in the absence of transference. It also serves as a theoretical context in which more contemporary psychoanalytic work in the seeming absence of transference or transference that 'feels' blank among patients otherwise seemingly functional might be reviewed.

2.8 On practicing psychoanalysis in the seeming absence of transference – A review of the contemporary psychoanalytic literature.

Despite the variety of definitions in the contemporary psychoanalytic literature (Ehrenreich, 1989), the transference is recognized across the current plurality of psychoanalytic approaches as an access route or 'royal road' to the unconscious (A. Freud, 1965; Sandler, Holder, Kawenkoka, Kennedy & Neurath, 1969). It is for this reason that transference interpretation is generally accepted as a key tool in effecting unconscious or intra-psychic change (Bird, 1972; Schwaber, 1990; Cooper, 1992; Kernberg, 1993, 1999; Riesenberg-Malcolm, 1995; Galatriotou, 2000).

A number of psychoanalytic writers have, however, documented and described their clinical experiences (and successes to varying degrees) in working psychoanalytically with patients where the transference has been variously described as: "destined to be still born" (McDougall, 1978, p. 245); devoid of affect or lacking in "real emotional contact" (Klein, S. 1980); dead (Ogden, 1995); indifferent (Quinodoz, 1996, p. 324); devoid of

meaning (Eshel, 1998, p. 1120); autistic (Liberman, 1958; Kanner 1944; Gomberoff, p. 253); or as "the unbearable presence of nothing" (Emanuel, 2001).

These analysts all seem to describe patients who while seeming to be suitable candidates for psychoanalysis, present over time with the common clinical feature of inaccessibility where interpretation seems to be without effect and the analytic process rendered stagnant as a result.

McDougall (1978, p. 227) for example describes the kind of patient – the "anti-analysand" - who while presenting as a seeming suitable candidate for psychoanalysis, over time presents with what she describes as;

> A vast chasm [that] seems to separate the anti-analysand from his instinctual roots, giving the impression that he is also out of contact with himself, that this is not restricted to his inner and outer objects.

Sydney Klein (1980) similarly describes his experience in working with what he calls "autistic phenomena in neurotic patients" (p. 395). Drawing on his experience with a patient who at first seemed to be a suitable candidate for psychoanalysis, Klein, S. (1980, p. 395) writes for example that,

> It gradually became clear that in spite of the analysis apparently moving along, the regular production of dreams, and reports of progress, there was a part of the patient's personality with which I was not in touch. I had the impression that no real fundamental changes were taking place.

In a paper published in 1996, Danielle Quinodoz documented her clinical experience of working with what she described as "an adopted analysand's transference of a 'hole-object'" and her paradoxical countertransference feeling of "existing in the transference as a non-existent object".

Quinodoz's (1996) patient, adopted at six months, felt that prior to this time and in relation to her biological parents who abandoned her at birth, she did not exist.

Alongside of the material that emerged in her analysis pertaining to her life with, and in relation to her adopted parents, was this feeling of non-existence that belonged to the first six months of her life and that manifested in an area inaccessible to analysis and a transference that felt "indifferent".

In her paper entitled "Black Holes', deadness and existing analytically" Eshel (1998, p. 1115) describes the technical challenges involved in treating analytically the emotionally disconnected patient "unable to form object relations of closeness, love and intimacy". Attributing the patient's emotional disconnectedness and transference that seemed to be "devoid of meaning" to the impact of the psychically 'dead' mother and, drawing on the astrophysical concept of a black hole to capture her patient's experience, Eshel (1998, p. 1115) writes for example that,

> The psychically dead mother constitutes a 'black hole' experience in the interpersonal, intersubjective space of her child because of the intense grip and compelling pull of her world of inner deadness. Individuals under her influence are either trapped in her deadening world or, if they succeed in detaching themselves, are petrified in their interpersonal space, because of the imminent threat of being drawn back in again.

It is interesting to note that all the patients described by the analysts above seem to demonstrate an emotional disconnectedness that belongs to an area of functioning that falls outside the area of the analyst's influence or that is beyond the reach of the therapeutic relationship.

Manifesting in the form of seeming absent transference or transference that 'feels' blank, the inaccessibility or areas of inaccessibility that become evident during the course of these patients' analyses suggest psychopathology that can be traced back to a stage that echoes the objectless state of Freud's (1915b) primary narcissism or functioning in a position that precludes relations to objects and prior to Melanie Klein's (1946) paranoid schizoid position.

In attempting to account for the most primitive aspects of human experience, pathology that seems manifest in areas of inaccessibility, and transference that appears to be absent as a result, Ogden (1989, p. 127) has postulated an "autistic-contiguous position" that predates Melanie Klein's paranoid schizoid position.

According to Ogden (1989) the wide forms of pathological autism ranging from infantile autism to autistic features of patients who have in other ways achieved a predominantly neurotic psychological structure can be traced back to disturbance in this primitive position. It is pathology traced back to a position earlier than Klein's paranoid schizoid position in other words that seems to account for the pathological autistic states constituent in an "insulated closed system of sensory dominated experience" that precludes relations to human objects and manifests in analysis in a seeming absent transference (Ogden, 1989, p. 129).

Hard to miss in these kinds of patients who present as seemingly suitable candidates for analysis but who over time reveal disconnectedness from both the analyst and the process, are the parallels with Winnicott's (1960a) conceptualization of a false/true-self split.

It is as if the pathology that belongs to the absent transference of the kinds of patients described in this literature seems to fit with Winnicott's (1952; 1960a) idea of a true-self locked in a pathological state of isolation where, as a result of the false-self protecting and hiding it – "holding" the true-self in other words - the true-self remains withdrawn and isolated from external reality and objects in it.

It might therefore be that the kind of psychopathology arising from adaptive failure during the very earliest stages of the infant-mother relationship and involving a false-self hiding and protecting a true-self, accounts for why some patients can present in analysis as suitable candidates with a show of being real (false-self) on the one hand, while another aspect of their personalities remains inaccessible and out of reach (true-self) on the other.

Gomberoff et al (1990), cite the attention that Rodrique (1966) has drawn to two kinds of "autistic transference" which if read as a constellation appears representative of an aspect each of Winnicott's (1960a) false/true-self split.

For example, in describing the first kind of autistic transference, which I am suggesting belongs to the false-self arm of Winnicott's (1960a) false/true-self split, Gomberoff et al (1990, p. 252), write that,

> It is not easy to detect, because the patient would be apparently connected to the analyst; he receives the interpretation and he responds to it with interesting and confirmative material; yet, this is a 'pseudo-response'.

The second kind of autistic transference that Gomberoff et al (1990) write about seems to capture, or is captured by, Winnicott's (1960a) idea of a true-self hidden, protected and hence isolated and withdrawn from contact with external reality and objects in it. In describing the second kind of autistic transference, which I am suggesting belongs to the isolated true-self arm of Winnicott's (1960a) false-self/true-self split, Gomberoff et al (1990, p. 252) write for example that;

> The second type of transferential autism would be that described by Kanner, where the 'analyst object' does not exist for the patient, yet the patient's inner world is perfectly clear and visible to the analyst but absolutely inaccessible, as if there were a glass in between.

Sidney Klein (1980) seems to capture Winnicott's (1952; 1960a) idea of a true-self pathologically isolated from contact with external reality with a false-self hyper-vigilant in its defence of, and search for conditions in which the true-self might come into being. For example, in describing the parts of his patient's personality that are inaccessible, and transference that "lacks real emotional contact", Sidney Klein (1980, p. 395) refers to what he has called "autistic phenomena" and what Rosenfeld (1978) has called "psychotic islands" in the personality as;

> …an almost impenetrable cystic encapsulation of part of the self which cuts the patients off both from the rest of his personality and the analyst…this

> encapsulation manifests itself by a thinness or flatness of feeling accompanied by a rather desperate and tenacious clinging to the analyst as the sole source of life accompanied by an underlying pervasive feeling of mistrust, and a preoccupation with the analyst's tone of voice or facial expression irrespective of the content of the interpretation.

McDougall's (1978) clinical description of her anti-analysand's "robotlike character structure" that enables a "correctly programmed" response, manifest in what she describes as "a sort of transference from an habitual relationship pattern, but its roots in the infantile past are difficult to discern since the world of internal objects is also somewhat delibinized" (p. 227) echoes Winnicott's (1960a) false/true-self split further.

The absent transference that McDougall (1978, p. 245) describes as being "destined to be still born" and which I am suggesting belongs to the true-self pathologically isolated from contact, is attributed by McDougall (1978, p. 227) to "the small child of former times urgently [having] had to create a void between himself and others, wiping out their psychic existence and so stifling intolerable mental pain".

In explaining the defensive function of this robotlike façade, reminiscent of the defensive function of Winnicott's (1960a) false-self, McDougall (1978, p. 230) writes for example that,

> Neither repression nor pathological projective identification predominates in this defensive system. Instead, these patients would appear to have constructed a sort of reinforced concrete wall to mask the primary separation on which human subjectivity is founded – an opaque structure that impedes free circulation both in inner psychic reality and between the internal and external world. This approaches what Winnicott called the *false-self* construction, in which an attempt is made to keep alive a sensitive inner self that dares not move, while an outer shell is maintained to adapt to all that the world is felt to demand.

Paralleled to McDougall's (1978) anti-analysands and the false-self arm of Winnicott's (1960a) false/true-self split, Bollas (1987) has described patients suffering from what he has called "normotic illness" and the technical problems involved in treating analytically these seemingly "abnormally normal" patients.

According to Bollas (1987), normotic illness involves the individual in the annulment of internal reality and the erasure of subjectivity. The normotic patient, like Winnicott's (1960a) false-self, appears so firmly entrenched in external reality as to be "ill in the opposite direction of those suffering from a loss of reality sense" (Winnicott, 1960a; Bollas, 1987).

It appears further from a review of Bollas's (1987) work on normotic illness that like the defensive function of the false-self which leaves a true-self isolated, undeveloped, impoverished and seemingly inaccessible analytically, the normotic defence betrays an area of underlying psychological functioning that Bollas (1987) refers to as the "unborn". In this regard, Bollas (1987, p. 140) writes for example that;

> It is striking how this person seems to be unborn. It is as if the final stages of psychological birth were not achieved, and one is left with a deficiency.

In the same way that Winnicott (1960a, p. 143) describes the essential lacking of the false-self as a true-self with "Me and not Me clearly established" – the patient's subjectivity in other words, Bollas (1987, p. 141) describes what is lacking in the normotic patient as "that originating subjectivity which informs our use of the symbolic".

Both Winnicott's (1960a) false-self and Bollas's (1987) normotic patients lack spontaneity; personal impulsiveness and creativity that belong to the arena of true-self functioning and creative living in the world.

Having replaced spontaneity, subjectivity or what Winnicott (1960a) would call "Me clearly established" with compliance and imitation, neither Winnicott's false-self, Bollas's normotic, nor McDougall's anti-analysand is capable of establishing and maintaining authentic and emotionally meaningful contact. As a result, object relations and hence also transference relations among these kinds of patients are established on the basis of compliance and imitation rather than true co-operation and authenticity.

In describing the "patient who is difficult to reach", Betty Joseph (1975) has drawn attention to a group of patients who like those described in this review "seem apparently highly co-operative and adult – but in whom this co-operation is a pseudo-co-operation aimed at keeping the analyst away from the really unknown and more needy infantile parts of the self" (p. 49).

It is not hard to see how the splitting that Joseph (1975) describes in her patient's who are difficult to reach, echoes Winnicott's (1960a) conceptualization of pathology in terms of a false/true-self split and accounts for the kinds of patient's who present in analysis as seemingly suitable candidates but who over time remain inaccessible and unmoved by interpretations.

Implicit in Joseph's (1975) work on the patient who is difficult to reach; Bollas's (1987) normotic patient, McDougall's (1978) anti-analysand and Winnicott's (1960a) false-self, is the idea that the transference or aspect of the transference that constitutes the working alliance or real relationship is a pseudo transference and that this pseudo transference manifest in a working alliance that turns out to be false, hides and/or renders inaccessible an underlying area of extreme vulnerability belonging to an undeveloped primitive aspect of the patient's personality.

It is this underlying area of extreme vulnerability inaccessible to analysis that seems manifest in what has been variously described by some analysts as "transference that is destined to be still born" (McDougall, 1978); non-existent; devoid of affect, lacking in real emotional contact, autistic or dead. It is also this primitive undeveloped aspect of the patient's personality that parallels Winnicott's (1952; 1960a) true-self pathologically isolated and withdrawn from contact with external reality; the unborn of Bollas's (1987) normotic patient; and the so-called "difficult-to-reach" parts of the kinds of patient's described by Joseph (1975).

In capturing the idea of absent transference further, a number of analysts describe defences used by patients that like Winnicott's (1960a) false/true-self split result in areas

of the patient's personality that seem inaccessible to analysis and that remain unmoved by interpretation.

Drawing on Francis Tustin's (1980; 1981; 1986) work on autism and concept of the "autistic object", Gomberoff et al (1990) describe patients who transform the analysis or aspects of it into an autistic object that traps the analyst in what they describe as a "transference/countertransference relation, which constitutes an autistic amalgum" (p. 253).

In explaining the fusion of this "autistic amalgum" which functions to reconstruct the primary unity with the primary object and ward off anxiety over two-ness, Gomberoff et al (1990, p 253) write that,

> Such fusion distorts the analytical function, precluding observation. A barrier is formed which is difficult to eliminate through interpretation.

Case material used by Gomberoff et al (1990) shows how a patient in analysis transformed and used verbal language as an autistic object that was at first difficult to detect. By clinging to the analyst's words, inserting them "in the middle of his talk", in making them "fit into a compact whole" and trying "by all means that his discourse should not disagree with that of the analyst", the patient constructed a fusion with the analyst in which "there was no 'I' and 'not I', there was no gap, there was only one" (p. 256).

While seemingly eloquent and intelligent, Gomberoff et al (1990) describe how the analyst struck by the richness of the patient's verbal language "did not realize at first that this tool was in the service not of useful communication but rather of 'pseudo-insight', pseudo-communication, pseudo-analysis" (p. 256).

Once again, hard to miss in this description are the parallels with Winnicott's (1960a) false-self. The idea of autistic objects being used in the service of the defensive function

of the false-self with compliance as its main feature seem clearly evident in this case material described by Gomberoff et al (1990).

Also evident in this material is the way in which the patient's "compliance", pseudo communication, pseudo insight functions to re-establish unity with the primary object and avoid the anxiety in relation to separation which is experienced as a laceration or mutilation of the self (Gomberoff et al 1990).

In her paper entitled "On the survival function of autistic manoeuvres in adult patients", Mitrani (1992, p. 549) brings attention to the "self-soothing" function of the kinds of defences that encapsulate aspects of the personality in a seemingly impenetrable "autistic enclave" and account for their manifestation in the room in a seeming absent transference or transference that 'feels' blank.

Drawing on the work of Tustin (1980, 1982, 1986, 1990); Klein, S. (1980); Innes-Smith, (1987); Ogden, (1989); and Gomberoff et al, (1990), Mitrani (1992, p. 549) writes that,

> autistic manoeuvres serve as a protective shell against the terrifying awareness of bodily separateness and dissolution into nothingness.

In explaining the self soothing function of autistic manoeuvres in adult patients, Mitrani (1992) draws on case material to show how patients make use of "autistic shapes" (Tustin, 1984), "autistic objects" (1980) and/or other "sensation dominated delusions" to "contain unmentalized experiences, protecting the patient from unbearable feelings of the catastrophic loss of and painful longing for the primary object, which threaten the subject with overwhelming anxiety" (p. 550).

Mitrani (1992) describes for example how a patient used the soft sensation of her tongue in her mouth as an "autistic shape" to provide her with "continuous comfort and protection against unbearable feelings of falling and emptiness" when she felt disappointed and alone (p. 552).

At times in the analysis when the patient felt “dropped” and “wounded” by the analyst, Mitrani (1992) describes how the use of this “autistic shape” while providing comfort to her patient also seemed to “stop up the analytic work, interfering with the kind of healing which comes through interaction with a caring human being” (p. 552).

Another patient described by Mitrani (1992, p. 553) made use of “hard autistic objects” to provide comfort and protection against “unbearable feelings of falling and emptiness” (p, 553).

Struck by this patient’s lack of verbal expression of any feelings, Mitrani (1992) struggled for over a year to decode her patient’s idiosyncratic expression of emotional states, which occurred in terms of “substances, movements and physical sensations in various parts of his or others’ bodies” (p. 553).

Mitrani (1992, p. 553) explains for example that,

> He spoke of his tears as moisture, without reference to feeling sad; his nostrils twitching, without the notion of anxiety; his feet moving, without the experience of arousal.

According to Mitrani (1992), her patient’s longing for her over the weekend break was not experienced or felt emotionally, but rather “heard as a barking dog which startled him out of bed on to the floor, gasping for air” (p. 553).

Mitrani (1992) describes how outside of analysis her patient used “masturbation” to stop the twitching of his nostrils and “the wiggling of his feet in a rhythmic way”. His use of “earplugs” was “to keep him from spilling, frightened, out of bed” (p, 553).

Inside of analysis, Mitrani (1992) describes her patient’s “stone wall of silence” or merciless finger biting as hard autistic objects used to ward off “contact with the more vulnerable soft center of his experience” (p. 553).

Drawing on Winnicott's (1951) work on the role of transitional phenomena and objects in describing the infant's healthy passage from symbiosis towards separation, it is interesting to note how these autistic shapes, objects and sensation-dominated delusions/experiences seem to function like Winnicott's (1951) transitional objects in providing the self-soothing comfort necessary to cope or tolerate the felt absences of, or separations from, the primary object and ward off the associated experiences of annihilatory anxiety.

However, unlike transitional phenomena/objects which, by virtue of being both symbolic of the mother and not the actual mother, facilitate the infant's journey from symbiosis towards independence by allowing the process of separating to take place without experiencing the annihilatory anxiety of separation, autistic objects, shapes and sensation dominated delusions function defensively to avoid the experience and knowledge of separation from the primary object by locking the vulnerable aspects of the patient's personality in a pathological state of primary narcissism with an object shape or sensation dominated delusion that is neither the actual mother nor symbolic of her care.

Like Tustin (1984) who traces the aetiology of psychogenic autism to failure in the earliest infant-mother relationship and consequent use of objects for their soothing tactile sensations as substitutes for the actual mother, Mitrani (1992) attributes what she describes as autistic manoeuvres which block out the unbearable agony of awareness of two-ness to what she calls "pathogenic distortion" of Winnicott's (1956) "normal primary maternal preoccupation".

For Tustin (1984), auto-sensuous objects like transitional phenomena are used for the tactile sensations they engender and for this reason in providing comfort at times of maternal absence or failure in adaptive care. However, auto-sensuous objects are pre-symbolic and only become transitional as a result of maternal care that imbues them with meaning and symbolic significance. It is therefore in the absence of maternal care that auto-sensuous objects are rendered asymbolic and become used pathologically as autistic objects.

By implication, in the absence of what Winnicott (1960b) would call good enough maternal care involving the actual mother holding and containing her infant – making sense out of her infant' s non-verbal communications (Mitrani, 1992), phenomena/objects that would otherwise become transitional and facilitate the processes of separation and development towards independence to unfold without the experience of annihilatory anxiety, remain without symbolic value and are rendered autistic instead.

In so far as objects are used autistically and not transitionally, to defend against, or ward off, experiences of the annihilatory anxiety of separation, the processes that would otherwise facilitate and promote separating and development towards authentically independent integrated ego functioning and whole object relating are rendered stagnant.

Instead of leading to the discovery of objects experienced and accepted as separate from the self, auto-sensuous objects in the absence of good enough maternal care appear to lock patients in a closed off system of objectless self sufficiency that echoes Freud's (1915b) primary narcissism and the pathological autistic states described in the literature.

According to Ogden (1989, p. 131),

> Pathological autism aims at the absolute elimination of the unknown and the unpredictable…[involving the individual in]…sensory dominated ways of being (more accurately a way of not-being) that are designed to insulate a potential self (that never comes into being) from all that lies outside of his sensory-dominated world.

The use of sensory dominated experiences is not, however, limited to severe cases of autism, psychotic or borderline patients. These experiences persist even in seemingly functional patients and are aimed at defending against what Ogden (1989) calls "autistic-contiguous anxiety" involving the fear of "impending disintegration of one's sensory surface or one's 'rhythm of safety' and felt as "leaking, dissolving, disappearing or falling into shapeless unbounded space" (p. 133).

Defences generated in the "autistic-contiguous position" that Ogden (1989) describes are according to him aimed at "the re-establishment of continuity of the bounded sensory surface and ordered rhythmicity upon which the early integrity of self rests" (p. 134).

Drawing on case material, Ogden (1989) describes activities of his patient during the analytic hour that can be thought of as "self-soothing uses of autistic shapes". These kinds of activities include for example "hair twirling, foot tapping, stroking of the lips, cheek or ear lobe, humming, intoning, picturing or repeating a series of numbers, focusing on symmetrical geometric shapes on the ceiling or wall or using a finger to trace shapes on the wall next to the couch" (p. 134).

It is these activities that like those described by Gomberoff et al (1990) and Mitrani (1992) perform a self-soothing function. However, unlike the use of autistic objects, shapes and sensation dominated delusions that aim at reinstating unity with the primary object to ward off the annihilatory anxiety of separation and awareness of two-ness, Ogden (1989) emphasizes the self soothing function of activities used as autistic shapes to ward off the kind of anxiety related to the feeling that ones' bodily integrity or sensory cohesion is at stake.

Again it seems plausible to suggest that in the absence of good enough mothering, autistic objects, shapes, sensation dominated delusions and or experiences develop to protect what Winnicott (1965; 1960b) might call the "going on being" or bodily integrity of the individual against the threat of annihilation and that like the defensive function of the false-self, these kinds of defences leave an underlying area of the individual's personality isolated, undeveloped and inaccessible.

Further defences generated in Ogden's (1989) autistic contiguous mode that function to reinstate the bodily integrity of the individual involve the patient in imitation and mimicry. It is as if in the absence of an authentic integrated sense of self or bodily cohesion that patients use imitation and mimicry defensively as a "second skin" (Bick 1968, Ogden 1989).

By assuming the qualities and characteristics of the object and using them defensively as a "second skin" or in a way that captures Meltzer's (1975) idea of *adhesive identification*, patients not only substitute for a deteriorating sense of cohesion, allay the anxiety of disintegration but present with a functional façade that seems to parallel the compliance of Winnicott's (1960a) false-self.

While Ogden (1989) does not liken imitation as a method of achieving a degree of cohesion of self to Winnicott's (1960a) false-self, in so far as both defenses result in an area of the patient's personality that remains undeveloped, unformed, unborn or define ways of "not being" in the world then, if not in parallel to the defensive function of the false-self, imitation and mimicry act at least in the service of the defensive function of the false-self in keeping isolated and pathologically withdrawn an area of the personality that in good enough conditions might develop. As Ogden (1989, p. 137) writes,

> Collapse in the direction of an autistic contiguous mode results in a tyrannizing imprisonment in a closed system of bodily sensations that preclude the development of a potential space…[and by implication a true-self with "me" and "not me" clearly defined].

More recently, Ricky Emanuel (2001) has explored and described various defences aimed at avoiding what he refers to as "the potentially annihilating terror implicit in the experience of contact with the void – the "domain of the non-existent' or nothingness" (p. 1069).

According to Emanuel (2001) these defences, universally employed to defend against contact with this domain – against sensing nothingness, involve the patient in a search for a fixed identity that structures their existence and fixes them in time and space.

In the absence of "good enough experiences with primary objects or attachment figures" and as a substitute for an internalized object to allay the anxiety of separation and in living outside the object, Emanuel (2001) explains how patients seek refuge inside an

object or state of mind as described in Meltzer's (1993) 'the claustrum' and Steiner's (1992) 'psychic retreats'.

According to Emanuel (2001, p. 1074),

> The fear of separation experienced as abandonment in the void or terror of non-being, akin to an infant animal being left exposed on a wide open plain without cover, can lead to the seeking of refuge as a form of containment inside an object.

By usurping the qualities of the object or in assuming a particular state of mind in other words, patients acquire a fixed sense of identity that structures existence and recovers lost time and space of the void. However, while anxiety inherent in sensing proximity to the void or domain of the non-existent is to some extent contained in this way, patients often experience what Emanuel (2001, p. 1073) describes as "intense claustrophobic anxieties, fears of being found out as an interloper, a chronic sense of fraudulence …and most profoundly, the terror of expulsion into the void – the nowhere place of the delusional system as described by Meltzer".

While it seems hard to miss how the defences described by Emanuel (2001) appear to belong to the defensive function of the false-self, it seems equally hard to miss the parallels between the domain of the non-existent and Winnicott's (1952; 1960a) idea of a true-self which as a result of the false-self remains pathologically isolated, withdrawn and therefore undeveloped or what might be referred to as 'unformed'.

It is therefore interesting to note that Emanuel (2001) emphasizes the main motivation for these defenses as "a-voiding the void" when it seems striking to note how like Winnicott's false-self, the use of these defences seem to create the very areas they seek to avoid.

As close reading of Emanuel's (2001) work shows, defences against the void, like Winnicott's false-self, involve the individual in a pseudo/fraudulent way of being in the world with an identity that is not their own and that the idea of living inside an object or

state leaves part of the personality like that of the true-self, isolated, inaccessible and undeveloped seems clearly evident.

Drawing on case material Emanuel (2001) describes for example how “once inside an object, the person becomes inaccessible to contact and views the world from the vantage point of the place inside the object” (p. 1074).

Emanuel (2001) explains further how a patient used grievance and resentment as a psychic retreat to avoid feeling “a nothing” or “nothing” and in providing her with a structure for her inner life that made her hard to reach in a way described by Joseph (1975).

Given the parallels between Emanuel’s (2001) work and Winnicott’s (1960a) false/true-self split, it seems plausible to suggest that the domain of the non-existent, manifest in a lack of transference, transference described as the unbearable presence of nothing or the transference of a strong sense of non-being, belongs to the true-self pathologically isolated from contact and therefore unformed, or unborn to use Bollas’ (1987) term.

It seems equally safe to say that if not in parallel with Winnicott’s (1960a) false-self then the kinds of defences that Emanuel (2001) describes, like those described in the rest of this review, act at least in the service of the defensive function of the false-self.

While the parallels between the defences described by the analysts in this review and Winnicott’s (1960a) false-self are striking, it seems no less striking that the removal of these defences, like that of the false-self, requires of the analyst something different than interpretation.

It is interesting to note for example that like Winnicott (1955) who in describing the kind of work involved in shifting the main site of functioning from a false-self to a true-self emphasizes management of the setting over interpretation, the kind of work described by the analysts in this review calls into question the centrality of transference interpretation

as a key tool in effecting intrapsychic change among the particular kinds of patient's they describe.

In so far as the removal of the false-self involves for Winnicott (1955) a shift in emphasis from interpretation to management of the setting, further parallels emerge in this body of literature and appear to center around the use of the countertransference, a corollary of which is to be found in Winnicott's (1956) concept of "primary maternal preoccupation".

For example, in the same way that Winnicott's (1956; 1960b) good enough mother uses her heightened state of identification – her primary maternal preoccupation to understand and meet her infant's needs empathically, that is reliably and not in a mechanistic way, the analysts in this study describe using their countertransference similarly in detecting the kind of pathology that seems manifest in a seeming absent transference or transference that feels blank, dead, autistic, indifferent or destined to be still born or devoid of meaning.

In working with her anti-analysand, McDougall (1978, p. 217) describes how she used her countertransference to pick up her patients transference that felt destined to be still born. She writes for example that,

> It is large through studying my countertransference feelings that I have become aware of the clinical picture I am describing and have arrived at certain theoretical deductions regarding the psychic structure and functioning of these patients.

Gomberoff et al, (1990, p. 253), cite Boschan (1987) who emphasizes the countertransference in "detecting autistic phenomena" and Paulan (1979) who described the repercussion in the countertransference of transferential autism pointing out for example that,

> the patient's withdrawal and avoidance of contact with the analyst can produce phenomena that may be designated by the generic term of countertransferential autism.

In describing the use of the countertransference in detecting the transference of a patient's internal object that was felt by the patient to be non-existent, Quinodox (1996, p. 323) writes for example that,

> The analyst may not immediately notice the special character of this object, but will discover it by examining his own countertransference in which he will have the paradoxical feeling of existing in the transference as a non-existent object.

In the seeming absence of transference, the countertransference emerges as taking center stage as a 'royal road' to the unconscious. In other words, in the absence of the classical route or royal road to the unconscious, the countertransference becomes a royal road to the patient's seeming absent transference. As demonstrated by the work of the analysts described in this review, it is the seeming absent transference that manifests in countertransference feelings of absence, deadness, boredom and these feelings in turn that provide a glimpse of what seems to parallel the idea of Winnicott's (1960a) true-self isolated, withdrawn, unformed, unborn or non-existent.

The idea of the seeming absent transference, feelings of indifference in the transference manifesting in the countertransference experience of the analyst or the countertransference being a royal road to the patient's seeming absent transference seems born out in particular by Quinodox's (1996) paradoxical countertransference experience of "existing in the transference as a non-existent object".

Equally interesting to note is how the countertransference is used in a way that parallels Bion's (1962) idea of containment whereby the mother takes in, processes, digests and uses the countertransference in understanding the patient's unconscious communication (Ogden, 1995).

In all these examples, the idea of absent transference or feelings of blankness in the transference emerges as a manifestation in the room of the symptom that comes for treating. And that rather than signal exclusion from psychoanalytic treatment, seems to suggest that something different than interpretation is required. It is again in this sense

that the kind work described in this review parallels that of Winnicott's (1955) idea that when working among patients who have not achieved integrated ego functioning and an intact capacity for whole object relating, the technical emphasis shifts from interpretation to management of the setting.

It is this body of work that appears to place in question the centrality of transference interpretation as a key tool in effecting intrapsychic change and in this sense also reflects interesting divergences from classical analysis and convergences with contemporary psychoanalytic modalities.

For example, common across these analysts' work, in their seemingly heroic efforts at working in the seeming absence of transference, or feelings of indifference, deadness, and/or meaninglessness in the transference, is their focus on the countertransference as a central unit of analysis, source of clinical data and means of informing interpretations and advancing otherwise stagnant therapeutic processes (Emanuel, 2001; Eshel, 1998; McDougal, 1978; Quinodoz, 1996; Klein, S. 1980; Ogden, 1995; Joseph, 1975).

Quinodoz (1996) for example explains the use of her countertransference in understanding her patient's indifferent transference or rather transference of indifference as "a defence against suffering the abandonment and violent aggressive drives towards the object" (p. 327).

Eshel (1998) describes how her countertransference plays a key role in informing the nature of analytic work when something more than interpretation is required as an agent of psychic change. In this regard Eshel (1998) explains the role of her countertransference in facilitating the analyst's function in these circumstances as a "sustaining, existing presence with no needs or demands…to absorb, bear and work through for [the patient] within [herself] alone, [the patient's] unbearable projections and …survive the world of death" (p. 1120).

In working with patient's where the transference feels blank or seems to be absent, Ogden (1996) explains the role of countertransference in formulating interpretations to the patient that give words so to speak to the patient's unspoken communications. More specifically he explains the role of countertransference in;

> generating verbal symbols that are eventually offered to the patient in the form of interpretations…where the goal of analysis is larger than [or different from] that of the resolution of unconscious intrapsychic conflict, the diminution of symptomatology, the enhancement of reflective subjectivity and self understanding, and the increase of a sense of personal agency (p. 696).

In his work with the kinds of patients where the transference does not appear to be explicitly evident, Ogden (1996, p. 708) also highlights the role of the countertransference in what he refers to as,

> creating analytic meaning from that which is unconsciously present in and powerfully shaping the analytic encounter but is foreclosed from the analytic discourse.

Closer scrutiny of the work of the analysts mentioned above suggest that in the absence of transference, the countertransference emerges as a "royal road' to the patient's transference.

For example, by analyzing her countertransference, Quinodoz (1996, p. 323) resolved the paradoxical experience of "existing in the patient's transference as a non-existent object".

Based on her countertransference experience, Quinodoz's patient's 'non-existent' transference could be seen as the transference of a non-existent object (i.e. a hole object) rather and in so doing rendered her patient's material analysable. In this regard Quinodoz (1996, 327) writes that,

> In analyzing my countertransference, I became aware that, by feeling 'non-existent', I was in the transference incarnating my patient's biological parents, for whom she felt no affect. In the transference I therefore had to give a face to the

> non-existent and the indifferent, so that Laure could become aware of her projections.

Similarly, by analysing his countertransference experience, Ogden (1995, p. 695) writes that he was able to,

> Measure the moment-to-moment status of the analytic process and in particular to address the specific expressive and defensive roles of the sense of aliveness and deadness of the analysis as well as the particular function of these qualities of experience in the landscape of the patient's internal object world and object relations.

Eshel (1998) also describes how the use of her countertransference transformed her patient's seeming absent transference into analysable material. She explains how analysis of her countertransference allowed her to transform an otherwise seemingly absent transference into the transference of "no-thingness', a symbolisable absence where feelings and thoughts may enter, to be felt and thought about" (p. 1123).

By analysing her countertransference, Eshel (1998, p. 1120) describes her analytic role as follows;

> Adam needed me here as a sustaining, existing presence, with no needs or demands of [my own] for him to be concerned about; to absorb, bear and work through for him within myself, alone, his unbearable projections and his (and my) world of death. And that is what I became.

In terms of how this material relates to the transference, Eshel (1998, p. 1120) explains further that,

> This may be regarded as 'background transference (Grotstein, 1993), which has an inordinately important function in such an analysis, even though the analyst, as an object, is unimportant in her own right (the analyst is a 'background object or presence', coinciding with Winnicott's 'holding environment object'.

It is interesting to note that while this body of work serves as a model of how psychoanalysis might be practiced in the seeming absence of transference, when read in

relation to Freud, Klein and Winnicott's work, however, the divergences from classical psychoanalysis and convergences with more contemporary varieties of psychoanalysis appear reflected.

The shifts from classical psychoanalysis that appear reflected in this work include 1) formulations of psychopathology, 2) a patient's suitability for psychoanalysis and 3) the technical requirements of effecting psychic change/cure. These shifts all seem consistent with the developments in psychoanalytic theory and practice since the 1950's, particularly evinced in the analytic work with narcissistic, borderline and psychotic patients - the kinds of patients Freud would have classically excluded from psychoanalysis on the grounds of their failure to produce transference.

These developments resulting in the 'widening scope of psychoanalysis' (A. Freud, 1954) and defining more contemporary varieties of psychoanalytic practice since the 1950's appear reflected in the work described by the above analysts in terms of: 1) a broadening of the definition of the transference to include all patient-analyst interactions, and 2) a changed view of the countertransference as an obstacle to a key analytic tool (Heimann, 1950; Reich, 1951; Thoma & Kachele; 1987; Kernberg, 1993; Jacobs, 1999; Wasserman, 1999; Louw & Pitman, 2001).

In so far as these analysts from diverse psychoanalytic schools all appear to work in comparable or similar ways in the seeming absence of transference, support is suggested for Wallerstein's (1990) idea of an emerging common technical ground across historically competing psychoanalytic schools.

In this regard, the parallels that emerge with Winnicott's (1960a) work in what I have suggested is the absent transference belonging to the true-self hidden and protected by the false-self, it seems plausible to suggest an emerging common technical ground on Winnicottian terrain and a general psychoanalysis that belongs more to Winnicott's (1955) psychoanalysis involving a modification in classical psychoanalytic technique and a shift in emphasis from interpretation to management of the setting.

It is within the context of this kind of work that this study is located. Also, given both the parallels and differences between analysis and psychoanalytic psychotherapy, it seemed important and justified to explore the question on how local therapists might practice psychoanalytic psychotherapy in the seeming absence of transference.

It is therefore with the question of patients functioning seemingly outside the area of analysts influence that this research project is primarily concerned where a key aim involved exploring the corrective potentialities of the psychotherapeutic relationship in psychoanalytic psychotherapy that takes place not more than three times per week and most commonly only once a week.

It is with the kinds of patients that present in psychoanalytic psychotherapy with the kind of pathology that manifests in a seeming absence of transference or what I have operationalized as being an absence of explicit transference manifestations without making any direct verbal or affectively intense references to the figure of the therapist (either positive or negative), that his project is primarily concerned.

CHAPTER THREE

METHOD

3.1 Introduction

Based on the experience of a number of psychoanalysts documented in the international literature in working with patients whose internal objects are described as blank, missing, dead, non-existent, and where as a consequence, the transference in these cases is described in terms that suggest absence or feelings of blankness, the aims of this project involved exploring how local psychoanalytically oriented psychotherapists, as opposed to their international counterparts, work among patients where the transference seems absent or 'feels' blank.

However, given the difficulties of this particular formulation of absent transference or transference that 'feels' blank in recruiting local practising psychoanalytically oriented psychotherapists to contribute their clinical experiences of working under such seemingly extraordinary clinical circumstances, the idea of absent transference or transference that feels blank was refined to the absence of **explicit** transference manifestations.

On the basis of the various definitions of the transference documented in the international body of psychoanalytic literature and as detailed in the literature review of this study, the idea of working in the 'absence of explicit transference manifestations was operationalized to mean working in the **absence of a patient making any directly verbal or affectively intense references to the figure of the therapist.**

Thus, instead of exploring how psychoanalytically oriented psychotherapists work with patients where the transference seems absent or feels 'blank', the aims of this study focused on exploring how psychoanalytically oriented psychotherapists work with a patient (s) who never makes any directly verbal or affectively intense references to the figure of the therapist – that is, in the absence of explicit transference manifestations.

In light of the centrality of the transference and its privileged status as an analytic tool par excellence across the current plurality of psychoanalytic approaches, the central aims of this study included:

- an attempt at providing a context in which clinicians practicing psychoanalytic psychotherapy could talk in general about the role of, and emphasis they tend to place on, transference analysis and interpretation in their respective practices.

- a specific focus on exploring and describing psychoanalytic oriented psychotherapists' experiences of, and thoughts about, working with a patient (or patients) in the absence of explicit transference manifestations.

- an attempt at exploring and describing how theoretical concepts translate into practice in the room.

- an attempt at making some contribution towards the existing body of literature on the corrective potentialities of the therapeutic relationship.

In so far as the central aim of this study involved exploring and describing in detail what local psychotherapists actually do in situations where the transference does not manifest explicitly in the room, with a particular focus on describing how psychoanalytically derived concepts translate into practice – that is how they are 'lived out' and 'experienced' in the room by the participating therapists, the phenomenological method of enquiry and data analysis was considered most appropriate.

However, by contrast to a strict or orthodox use of the phenomenological method to derive a qualitative description of the essential nature and meaning of experiential phenomena as they are lived prior to that which is presupposed by theory (Von Eckhartsberg, 1972; Giorgi, 1975), phenomenological methodology was used for the main purpose of explicating the essential meaning of key psychoanalytically derived

concepts and principles as they are experienced both subjectively in the room and thought about objectively by the participating therapists in this study.

Given the various definitions of the transference for example, it seemed important to explicate phenomenological meanings of psychoanalytically derived concepts and describe these in terms of how they are 'lived out' and 'experienced' in the room from the therapists' perspective.

As a means of both remaining true to the participating therapists' expressions in their own language of their experiences of, and thoughts about, working in the absence of explicit transference manifestations, and for explicating from this material the phenomenological meaning of key psychoanalytic concepts, a modification of the use of the phenomenological method rather than its orthodox use seemed justified.

Further justification for modifying the use of phenomenological praxis derives from the fact that psychotherapy, albeit an unusual experience nevertheless constitutes an experience worthy of investigation and ongoing research (Fessler, 1978; Becker, 1987; Stevenson, 1987; Kruger, 1979; Thorpe, 1989; Scott, 1993).

3.2 Respondents

The four therapists who participated in this study were all female, English-speaking; well-established and experienced clinicians practicing psychoanalytically oriented or informed psychotherapy within the Gauteng region. The participating therapists were recruited from a data base of some 60 psychoanalytic psychotherapists and were included in this study on the basis of their: -

1. Status as registered clinical psychologists with the Health Professions Council of South Africa (HPCSA). (In keeping with my ethical obligations to protect the confidentiality of the participating therapists, their names, registration and practice numbers have been excluded)

2. Training and experience, exceeding 10 years, in the practice of psychoanalytically oriented psychotherapy (R1, R2 and R3) and supportive psychotherapy (R4); and

3. Willingness to contribute freely and comfortably their respective clinical experiences of, and thoughts about, working with a patient (or patients) in the absence of explicit transference manifestations. On the basis of this formulation of absent transference or transference that feels blank, all the participating therapists were advised that the research question focused on exploring their clinical experiences of, and thoughts about, working with a patient or patients who never make any directly verbal or affectively intense (either positive or negative) references to the therapist.

Further details pertaining to the participating therapists' preferred theoretical orientations, status as therapists in therapy, clinicians in supervision and members of local reading groups are evident in the individual interviews and data analysis section (book 2) of this study.

With the exception of R4, therapists R1, R2 and R3 were all in supervised practice and members of local psychoanalytic reading groups at the time of conducting the interviews for this project. Only R1 divulged being in her own therapy. Therapists R2, R3 and R4 did not disclose information pertaining to their status as clinicians in therapy. All the participating therapists are supervising practitioners of other clinicians.

The patients described by the therapists in this study were all in long term, once-a-week, face-to-face psychotherapy for a period exceeding 2 years.

In terms of the relevance of R4's contribution to this study, it is important to note that while she claims a supportive therapeutic stance precluding a focus on interpreting or working in the transference, her use of the transference and countertransference as key diagnostic tools suggests a psychodynamically informed mode of supportive psychotherapy. Also, at the time of treating her client whose clinical presentation and

material is of relevance to this study, R4 claims having worked within an object-relations orientation. Thus, while the relevance of her contribution is at face value questionable, it is her knowledge, experience and use of psychodynamic principles in her supportive practice that renders her contribution a more valid one than would seem immediately apparent.

3.3 Data Collection

3.3.1 Data-generating questions

The core research question was how local psychoanalytic psychotherapists practice psychoanalytic psychotherapy in the absence of explicit transference manifestations.

Accordingly, each participating therapist was asked to describe in as much detail as possible their respective experiences of, and thoughts about, working psychoanalytically with a patient or patient's who never make any directly verbal or affectively intense references to the figure of the therapist.

In order to enhance understanding and comprehension of the research question, the participating therapists' experiences of, and thoughts about, practicing psychoanalytic psychotherapy in the absence of explicit transference manifestations were first sought within the context of practicing psychoanalytic psychotherapy generally.

Given the exploratory nature of the study as well as the complexity of the topic, an open-ended semi-structured interview was compiled (see Book 2, Appendix 3, p. 158). This was used as a guide only to focus the interview on the phenomenon in question and to locate it within the context of the participating therapists' experiences of practicing psychoanalytic psychotherapy more generally.

To orient the participating therapists more specifically to the research question, each therapist was first asked to talk about and describe the theoretical orientation that informs

their work. They were also asked to indicate the ways in which their theoretical orientation might be reflected in their practice with a particular emphasis on the techniques that they apply. In this regard, each therapist was asked to comment on the role and emphasis placed on transference analysis and interpretation generally.

Once a context was established in this way, the remaining focus of the interview centred on exploring the therapists' *actual* experiences of, and thoughts about, working with a patient or patients in the absence of explicit transference manifestations.

Descriptions of examples from actual case material to illustrate theoretical or technical points related to the phenomenon in question were sought and elaborated on. Prompting questions were used to elicit more in-depth descriptions and to maintain the flow of the interview as it focused on particular case material and clinical experiences pertaining to the research question.

From time-to-time, reflecting comments on what the respective therapists said were made in order to clarify and/or confirm understanding. While this made for somewhat repetitive questioning at times, the value of this interviewing technique lies in the extent to which repetitious questions yield many descriptions that allow the experience of the phenomenon to be differently described thus bringing new meaning to the experience (Giorgi, 1989).

3.3.2 The Data-generating situation

The participating therapists were interviewed between June and July 2003. For convenience sake, all the interviews took place at the therapists' places of practice. Each interview was recorded on a 90-minute tape and lasted between 45 and 50 minutes. All the tapes were transcribed verbatim by the researcher and comprised the interviews of protocols to be analysed (see Book 2, Appendix 1).

3.4 Ethical Considerations

The participating therapists were informed that the research topic involved exploring their experiences of, and thoughts about, working in the absence of explicit transference manifestations.

All the therapists in this study were advised that their participation was voluntary and that they would be free to withdraw without consequence at any stage.

To ensure confidentiality, all identifying data pertaining to all parties concerned were excluded.

Signed consent to tape record and transcribe the interviews was obtained from each participating therapist upfront (See Book 2, Appendix 4, p. 160 for a sample of the consent form). All the therapists in this study were also advised that this research report would be made available for public scrutiny in the university library.

3.5 Data Analysis

Phenomenological analysis of the data as described by Giorgi (1978) and Kruger (1979) was carried out as follows: -

3.5.1 Initial reading of the interviews (protocols)

Each transcript was read a few times to get a sense of the material as a whole. This was done each time while listening to the respective tape in order to ensure accuracy and to enhance comprehension of the material (see Book 2, Appendix 1).

3.5.2 Determining and delineating the Natural Meaning Units (NMU's)

Each interview was read through with the aim of determining the nature meaning units as expressed by the participating therapist. A natural meaning unit (NMU) refers to "each statement made by [the therapist] which is a self-definable and self-delimiting in the expression of a single, recognized aspect of the [therapist's] experience" (Cloonan, 1979, p. 117).

NMUs are separately analysable components of text. They constitute the smallest amount of information that reflects the presence of a theme, which can vary from a phrase to an entire paragraph.

In this study, particular care was taken to remain true to each participating therapist's experience and the context in which such experience was expressed. Irrelevant and unclear data as they emerged from time-to-time were excluded from the process of determining and delineating the NMU's (see Book 2, Appendix 2).

3.5.3 Regrouping of the Natural Meaning Units into themes

In each interview, the NMU's were regrouped according to their various meanings/themes (Von Eckartsberg, 1972). While data collected involved both the context in which the therapist's practice psychoanalytic psychotherapy generally and in the absence of explicit transference manifestations, the NMU's were grouped according to their various meanings/themes as these pertained to the general context in which the therapists practice psychoanalytic psychotherapy generally and as they pertained to the actual research question more specifically.

Great care was taken to ensure that the regrouping of the meanings and themes remained true to the therapists' experience and the context in which the expression of these experiences pertained.

The NMUs were regrouped into themes based on the nature of therapeutic action and or guiding principles as these emerged from the interview, both prompted by the guiding questions and those that emerged spontaneously throughout the interview.

Inter-rater reliability of the regrouped natural meaning units into themes as well as the extended description of each interview was ensured by two trainee clinicians well versed in the theory and practice of psychoanalytically oriented psychotherapy. The trainee therapists were each given copies of the transcribed interviews with the request to verify the regrouping of the natural meaning units into themes.

3.5.4 Central Themes **in each** interview (see Book 3, Appendix 5)

The themes that emerged in **each** interview were regrouped/organized and expressed more directly in terms of the contextual categories pertaining to the research topic. A contextual category derived from the particular questions comprising the semi-structured interview. For example, "The role of theory" as a contextual category derived from questions pertaining to the therapists' respective theoretical influences/orientation.

As far as possible the central themes as experienced were described in the therapists' own language. Themes occurring only once were included if considered relevant to illuminating particular experiences.

The central themes pertaining to each interview were formulated into an **extended description** of each participating therapists' experience.

The analysis of central themes and extended description of each interview were articulated in the third person and constitute the first level of data analysis of this project.

Upon completing the analysis of each interview as well as each extended description, copies were forwarded to the respective therapists to confirm accuracy and/or omissions. These are presented in Book 3, Appendix 6 of this research report.

3.5.5 Central themes **across** the interviews

The central themes in each interview were regrouped and categorized across the interviews as a whole. An extended description that broadly described the central themes that emerged across the participating therapists' experiences of, and thoughts about, practicing psychoanalytic psychotherapy both generally and more specifically in the absence of explicit transference manifestations was formulated. This section constituted the final level of data analysis and the main findings of this study.

CHAPTER FOUR

DATA ANALYSIS

Introduction

The participating therapists' experiences of, and thoughts about, practicing psychoanalytic psychotherapy in the absence of explicit transference manifestations were sought, and therefore emerged, within the context of their clinical experiences of, and thoughts about, practicing their particular 'brand' of psychoanalytic psychotherapy generally.

In order to remain truly reflective of these contexts, the data pertaining to the therapists' experiences of, and thoughts about, the role of the transference and instances of working in the **presence** of transference manifestations were included in the analysis. Another reason for including this data in the analysis is the extent to which it enhances both the meaning and understanding of the phenomenon in question in this study, namely the clinician's experiences of, and thoughts about, practicing psychoanalytic psychotherapy in the **absence** of explicit transference manifestations.

Since most of these experiences and thoughts emerged in terms of principles and functions performed by the participating therapists, most of the central themes as they emerged across the interviews as a whole are named or labelled to be reflective of these principles and functions. Wherever applicable, sub-themes, as they emerged and extended the meaning of the central themes, were included in the analysis. It is important to note that the themes are not ordered in terms of importance. Many of the principles adhered to and functions performed by the therapists in this study occur simultaneously in practice.

The chapter concludes with an extended description of the central themes that emerged across the interviews and constitutes the major findings of this study.

Analysis across all the interviews lead to a cluster of central themes in terms of the context in which the participating therapists practice psychoanalytic psychotherapy generally and central themes and sub-themes pertaining more specifically to the actual research question.

The central themes described in the third person with illustrative extracts from the interviews are presented as follows:

4.1 The role of theory - Informing assessment and diagnosis of the patient's level of functioning.

The therapists describe the influence of a range of psychoanalytic theorists and theoretical orientations. Three of the four therapists (R1, R2 and R4) mention either awareness, or the influence of, a diverse range of theorists and/or orientations. Only therapist R3 specifically mentions being influenced by Kleinian theory and describes her orientation as "a general object relations" orientation (R3, NMU 9, p. 116).

While R1 mentions the influence of Klein, Bion modern Klein, Steiner and Winnicott (R1, NMU 10, p. 77), R2 who describes herself as a "mixed breed" having read Winnicott, Klein Rosenfeld, Kernberg and Green describes herself as being more familiar currently with Freudian or what she calls "new" Freudian thought generally (R2, NMU 11 – 26, p. 95).

Having mentioned a background in Object Relations theory drawing mainly on middle school and Winnicottian thought, R4 describes working currently "more integratively" with a particular emphasis on "infant-parent relatedness" and "attachment theory". She also describes the influence of the Self Psychologists and mentions Kohut specifically. R4 has never "technically worked in a Kleinian methodology or even classically analytic Freudian" (R4, NMU 9 – 22, p. 138).

Despite having mentioned the influence of a range of diverse theorists and/or orientations, all the therapists indicate or suggest the importance of theory in understanding a patient and in assessing a patient's level of functioning rather than in informing a set of predetermined therapeutic techniques. Assessment and diagnosis of a patient's level of functioning emerges as a central guiding principle across all the therapists. The influence of theorists and theoretical orientations tend to be reflected in how the therapists in this study understand and assess their patients' level of functioning.

> …It would be much more drawing on understanding…how I would understand a particular patient…I can think of one where literally he couldn't think, so Bion came much more to mind…I see it not so much in terms of techniques but much more in terms of understanding where the patient might be at (R1, NMU 17 – 24, p. 77).

> …I think it has more to do with the understanding of the client rather than the techniques…I don't think I'm very focused on techniques at all…far more on the understanding of the client (R2, NMU 32 – 35, p. 95).

> …I'm thinking all the time what kind of internal object relation are we dealing with…whatever the person's talking about…that's kind of in the background of my mind. (R3, NMU 18 – 19, p. 116).

> …I am interested in the quality of attachment that the client has to me and what that might reveal about the patterns of attachment (R4, NMU 34, p. 138).

4.2 The centrality of interpreting/working in the transference

While R1, R2 and R3 explicitly recognize and acknowledge the importance of the transference in their work, they indicate that it is not always considered appropriate to interpret or work in the transference with every patient.

According to R1 for example, interpreting or working in the transference is generally not indicated among patients who resist transference interpretations.

> …I think it is very important…I do think that's where the work is done…sometimes I feel it's very hard…I think it's hard to do with patients who

> are very resistant to transference interpretations…(R1, NMU 58 – 62, p. 78). While I think it's very very important, with a lot of my patients I do work in the transference, there are some where I don't…(R1, NMU 70, p. 78).

While R2 recognizes that interpreting the transference is both a helpful and powerful technical tool, she is sensitive to its potential destructiveness as well.

> …if you can interpret something in the room it is very powerful…but not always appropriate…(R2, NMU 123, p. 97). Working in the transference is a very heavy tool that can be hugely helpful and hugely destructive (R2, NMU 547, p. 107).

R3 does not work exclusively in the transference because she is not always able to see how the transference is related to the material the patient brings into the room or how to formulate interpretations of the transference without her patient thinking she is mad or exclusively focused on herself.

> …I don't solely work in the transference even if I believe it was necessary I don't think I would be able to because I can't always see that it is related or how it is related…if I can see that it is related, I don't always know how to interpret it how to put it to the patient who will not think I'm just mad…I'm quite sensitive to the patient feeling, '*why's she talking about herself again*' . (R3, NMU 29 – 34, p. 116).

Unlike R1, R2 and R3, therapist R4 does not focus on interpreting or working in the transference. In keeping with her supportive stance and therapeutic style, which she describes as being "quite engaged" and "quite present", her focus on the transference centres on using it mainly as a diagnostic tool rather than a technical one.

> …I'm interested in the patient's experience of our relationship and where that might come from but it's not a primary focus of my work…(R4, NMU 53, p. 139). I often think about the transference and what the client is projecting on to me but I wouldn't say that it's a major focus of my work…I use it diagnostically, but I don't use it technically so much…I choose not to focus on that…(R4, NMU 71 – 74, p. 139)

Across therapists R1, R2 and R3 the centrality of interpreting or working in the transference depends on a number of criteria. Of all the criteria mentioned by therapists

R1, R2 and R3, five stand out as key. These are: 1) the patient's level of functioning; 2) the frequency of weekly sessions; 3) the affective nature of the patient's relation to the figure of the therapist (either positive or negative); 4) how the transference is treated and interpreted as a function of how it manifests as a resistance to the therapeutic process; and 5) the clarity of the countertransference.

4.2.1 The centrality of interpreting/working in the transference - A function of the patient's level of functioning

Therapists R1, R2 and R3 mention that it is generally considered more appropriate or applicable to interpret/work in the transference among more 'developed' or what might be called psychologically 'formed' patients in terms of ego functioning and object relating.

According to R1 interpreting the transference is generally not indicated among psychologically unsophisticated patients in fairly new therapies. She also emphasizes the importance of transference interpretations making sense to the patient. In other words, the patient must be able to understand transference interpretations.

> …I'm just thinking of a patient I saw this morning…again it's a fairly new therapy…he's very psychologically unsophisticated…if I was to make transference interpretations I don't think he'd come back…it's at the stage where he's still exploring in some ways who he is…transference interpretations wouldn't make sense to him…(R1, NMU 64 – 69, p. 78).

In R2's experience interpreting the transference is more applicable among patients capable of "Oedipal-plus" functioning with a capacity for symbolic thinking. Interpreting the transference is not indicated among more 'fragile' patients unable to become conscious of the unconscious.

> …In our practice, you very rarely have just exclusively straightforwardly neurotic patients who function on an Oedipus plus level…where you can directly refer to the feelings of the patient towards you…it will be taken on a symbolic level…there will be no mistaking of myself as the mother (R2, NMU 70 – 81, p.

> 96). Whereas if I compare that to another patient I have in mind where it would be close to unthinkable…very rarely would I refer to me because it terrifies the patient…and he will have nothing to do with it…he is certainly not in a state at this point where he would be able to be conscious about it (R2, NMU 83 – 93, p. 96).

In this regard, R2 does not see her first duty as making the unconscious conscious. Her focus centres rather on working at the level of the patient's ego and in understanding the patient. The centrality of interpreting or working in the transference for R2 emerges as a function of her ability to make sense of transference material and to communicate interpretations at the level of the patient's ego.

> …I do not think that my first duty is to uncover unconscious stuff…my first duty is to stay, if I can, with the ego of the patient…to follow the patient and to try and understand what is going on…this is very difficult with many patients, not all…if I can try and make sense of it in such a way that I can communicate it to the patient, well that's fine (R2, NMU 553 – 559, p. 107)

R3 implies the centrality of interpreting/working in the transference among more 'developed' patients in describing her difficulties in working in the transference with a patient who she experienced as "very adhesive", seemingly incapable of relationships, and without an authentic sense of self.

> …She keeps herself in a state that she's incapable of taking anything in…I actually despaired quite a lot about how I was ever going to help her because she couldn't take in any interpretations…it would kind of fall off…it's like she doesn't know how to have a proper relationship…she only knew how to pretend how to be somebody…she like pretends to be a human…(R3, NMU 332 – 343, p. 123).

While both R1 and R3 suggest the applicability of interpreting/working in the transference among more psychologically 'developed' or 'formed' patients as a general rule, they also mention that among more 'disturbed' or psychologically 'unformed' patients interpreting/working in the transference can be necessary **if** the transference manifests explicitly in the room. By implication, irrespective of a patient's level of

functioning, interpreting/working in the transference for R1 and R3 is indicated if transference material manifests explicitly in the room.

According to R1, working in the transference is often indicated among more psychologically 'disturbed' patients because in her experience with these kinds of patients the transference tends to manifest relatively quickly and explicitly.

> …there are some patients that you can start working in the transference very quickly…its actually the more disturbed patient in fact who gets quickly into that because the transference is a bit mad…then there are patients that after a long time I can start working more in the transference but that it does take time (R1, NMU 177 – 181, p. 81).

R3 also suggests the importance of working in the transference among more psychologically 'disturbed' patients if the transference manifests explicitly in the room. Drawing on her experience with a particular patient in mind, R3 says for example that,

> …he was in fact borderline and worked very much in the transference…it was as if he couldn't help it, his feelings towards me were very intense from the beginning and so I had to address them consistently (see Book 2 Appendix 6, p. 66)

According to R2, while it might be easier to identify the transference if it manifests explicitly in the room, it is not always easy to interpret or work in the transference because it is not always easy to know what it is about or what it belongs to. For R2, the centrality of interpreting/working in the transference does not automatically emerge as a function of whether transference material manifests explicitly.

> …if somebody is aggressive towards me and it's direct…it's relatively easy because it's clear…if you have a clear cut feeling…you still might not know what it is about or what it belongs to and what part of me or what function is attacked…but at least it's there…(R2, NMU 562 – 564, p.107).

In contrast to therapists R1, R2 and R3, therapist R4 works supportively with a focus on understanding and meeting her clients' needs without interpreting or working in the transference to make the unconscious conscious.

Speaking more generally R4 says for example that,

> …Firstly, depending on how I understand the client and the client's need…my practice is also quite varied, I don't only do long term work, so in the short term work, I work very hard to meet what the client's need is or what they client is asking for if it's parent counselling (R4, NMU 63 – 64, p. 139).

Drawing on her experience with a particular client in mind R4 says more specifically that,

> …transference interpretations were never applicable with him because the therapy is about his health and thinking a bit about his relationship…I don't think he ever really want to look at the dynamics of his inner world…I think he wanted to feel better (R4, NMU 362 – 363, p. 145).

While R4 indicates using the transference as a diagnostic tool rather than as a technical one, she also suggests that the transference manifests explicitly in the room as a function of the therapist's focus on it.

> …I think when you choose to focus on it then it comes alive…when you're always looking for it and when you're asking the client constantly to reflect on who you are for them, then you will become different people for them because that's how they'll language the therapy…it's never worked, it's not a language I use a lot I suppose (R4, NMU 91 – 95, p.139)

4.2.2 The centrality of interpreting/working in the transference - A function of the frequency of weekly sessions

While all the therapists suggest that the transference tends to manifest more explicitly in the room as a function of the frequency of weekly sessions, only R1 and R3 indicate the centrality of interpreting/working in the transference as a function of weekly sessions generally.

Despite having mentioned that the transference can manifest explicitly in the room as a function of the patient's underlying psychopathology where among more disturbed patients the transference tends to manifest relatively quickly and explicitly, R1 also

suggests that the transference tends to manifest explicitly as a function of the frequency of weekly sessions. According to R1 it is generally considered more appropriate to interpret/work in the transference the more frequent the patient's weekly sessions because the transference tends to manifest more explicitly in more frequent weekly sessions.

> …I think what needs to be taken into account is that we see people once a week and not everyday…the patient I told you about who was so furious with me I see her three times a week…it's so much easier to work in the transference the more often you work…seeing the patient once a week, it makes it that much more difficult to deal with (R1, NMU 686 – 691, p. 92).

Like R1, R3 suggests that the transference tends to manifest explicitly as a function of the frequency of weekly sessions. For this reason, R3 does not maintain an exclusive focus on interpreting/working in the transference on a once-a-week basis.

> …I think when you don't work four, five times a week its much more difficult…its much less intense and the person's much less even semi-consciously aware…so I don't focus solely on the transference…I do try to think in terms of what is happening (R3, NMU 36 – 39, p. 116).

While R3 mentions the centrality of interpreting or working in the transference as a function of the frequency of weekly sessions as a general rule, she emphasizes that it depends on the patient because there are some patients in once a week therapy with whom interpreting or working in the transference is indicated. According to R3 the centrality of interpreting/working in the transference is not automatically a function of the frequency of weekly sessions although as a general rule it tends to be.

> …it depends on the patient…I say it is much easier to work in the transference when it's more often, but it depends on the patient…I've had once a week people who are right there so it does depend…I do think as a general rule yes it is easier (R3, NMU 958 – 963, p. 137).

Like R1 and R3, R2 indicates that the transference tends to manifest more explicitly and intensively as a function of the frequency of weekly sessions where as a general rule the

more frequent the weekly sessions the more explicitly and intensely the transference tends to manifest.

> …there is a huge difference between once a week, twice a week and three times a week…each time there is a huge difference…one has to be clear what one offers a patient…it goes much deeper…once a week you have to carry it forth with a bow…(R2, NMU 760 – 763 & 773, p. 111)

Implicit in R2's interview, however, and in contrast to R1 and R3, the centrality of interpreting working in the transference does not emerge as a function of the frequency of weekly sessions but rather as a function of the patient's developmental status. In terms of once-a-week therapies, the centrality of interpreting/working in the transference emerges according to R2 as a function of the patient's capacity to hold the therapist in mind for the remaining six days. As a general rule interpreting or working in the transference is generally not indicated in once-a-week therapies among patient's incapable of holding the therapist in mind.

Likening the transference to a bow, R2 says for example that,

> …I call it the bow like the bow…people have different bows…a bow has a certain length and some use it up very quickly and others can hold it for a very long time and still play a beautiful tune on it…but the thing is…a lot of people cannot cope cannot do psychotherapeutic…deep psychotherapeutic work on a once a week basis…because they cannot hold you in their minds… it's really as if you were titillating them…because there you are for one session a week and then they have to go and live on it for the next six days…(R2, NMU 775 – 783, p. 111)

In so far as the transference manifests more explicitly in more frequent weekly sessions, there are some patients according to R2 who shy away from the greater intimacy implied by more frequent weekly sessions. In this regard, the scheduling of more frequent weekly sessions according to R2 is a function of the patient's level of functioning and capacity to manage the greater intimacy implied by more frequent sessions. In contrast to the kinds of patients who shy away from the greater intimacy implied by therapy twice a

week, there are other patients in R2's practice for whom therapy twice a week is still not frequent enough because they cannot 'hold' the therapist in mind for the rest of the week.

> …and of course some run away from that greater intimacy implied that would be implied and the greater need that would be implied by coming twice a week and some cannot survive on twice a week because they cannot keep that bow… (R2, NMU 783, p. 112)

Drawing on her experience with a particularly 'disturbed' patient in mind R2 indicates that the scheduling of more frequent weekly sessions also depends on the therapist's capacity to both manage and contain the greater tendency towards regression and surfacing of primitive 'psychotic' material that more frequent weekly sessions among psychologically 'disturbed' patients can imply. According to R2, the scheduling of more frequent weekly sessions among certain psychologically 'disturbed' patients is sometimes not indicated precisely because the implied greater tendency towards regression and surfacing of psychotic material in more frequent weekly sessions might pose too great a threat to the integrity of the patient's ego which in turn might also be too difficult for the therapist to manage and contain.

> …I would not offer this patient three times a week…I think twice a week is just fine…(R2, NMU 764 – 765, p. 112)…I would be worried because I think it would impinge on his ego functioning…that and the wish for regression becomes too big…I think there is quite a bit of…there could be quite a bit of psychotic stuff coming up that would then be difficult to contain…I'm not saying that it would be impossible…I feel that he is very able to make use of his twice a week…it seems that he can survive on it…(R2, NMU 794 – 801, p. 112).

In contrast to the kinds of patients for whom it is not indicated to schedule more frequently weekly sessions, R2 indicates the importance of scheduling more frequent sessions among more psychologically minded patients and in particular, patients with a profound knowledge of psychodynamic theory who easily use their knowledge defensively to resist the transference.

> …All that theoretically knowledge is so easily used as a defence…they might talk theoretically about what they have, but they can't bring it into the room because they fear the feeling and they are terrified that they themselves could be as sick as

> that…it helps to see them at least twice a week…if they come once a week then there's very little I can do…there isn't a chance for me to get them there…but with twice a week, you can and there is a huge shift happening (R2, NMU 859 – 885, p. 114).

In contrast to R2, and like therapists R1 and R3, R4 indicates the centrality of interpreting or working in the transference as a function of the frequency of weekly sessions where the more frequent the weekly sessions the more central interpreting or working in the transference generally is.

> …once you're seeing someone three or four times a week then therapy's part of your week…what else are you going to talk about…if you see your therapist more than you see anyone else in the week, of course you're going to talk about the transference…that's why you do see people so often so that you can talk about the transference…(R4, NMU 454 – 462, p.148)

However, in R4's predominantly supportive practice, interpreting or working in the transference is not central precisely because she tends to see clients once a week. According to R4, interpreting or working in the transference is unnecessary and not always in her clients interests on a once-a-week basis.

> …I only see patients only once a week…in once a week therapy it's not always in the client's interest…they don't always need to…(R4, NMU 643 – 652, p. 152).

Many of R4's clients can also only come to therapy once a week and sometimes only fortnightly because of pragmatic restrictions around time and money. According to R4 more frequent sessions also suggests analysis rather than supportive therapy. In this regard, R4 claims that she is not an analyst nor specifically trained analytically to work in more frequent weekly sessions. R4 feels that once-a-week therapies and even fortnightly sessions are suited to her clients needs to review their experiences in the week with her. In her once-a-week therapies, R4 does not encourage regression by interpreting or working in the transference because her clients need to function in the real world after therapy.

> …I mean just with restrictions in terms of time and money, most of my clients couldn't afford to come more than once a week…in fact then it's analysis and I'm not an analyst…I'm not trained in that way and I think that the therapy that I do is fine once a week…often my clients will review the week with me and especially the ones you see every two weeks then it's fine…I don't feel that we're doing therapy so much then as support because they come and review the week with me and run things by me, but the clients I see once a week, especially in the earlier phases of their therapy, it's very much that I don't encourage regression because they've got to go out there and work and live and function (R4, NMU 441 – 448, p. 147)

4.2.3 <u>The centrality of interpreting/working in the transference - A function of the affective nature of the patient's relation to the figure of the therapist (either positive or negative)</u>

Therapists R1 and R3 indicate the importance of interpreting or working in the negative transference in order to remove it as a source of resistance to the therapeutic process; to restore positive therapeutic relations and the patient's experience of the setting as a safe place and the therapist as a benign figure. For R1 and R3 the centrality of interpreting/working in the transference irrespective of the patient's level of functioning emerges as a function of whether transference material manifests explicitly as a resistance to the therapeutic process.

Among the kinds of patients described by R1 and R3, it is the negative transference rather than the erotic or idealizing positive transference that tends to manifest explicitly in the room as a resistance to the therapeutic process. Also, the negative transference among the kinds of patients described by R1 and R3 tends to be in response to "not feeling safe" (R1, NMU 232, p. 82) or not experiencing the therapist as a benign figure who the patient can trust (R3, NMU 191, p. 120).

R1 wonders for example if it is not generally speaking easier to work in the negative transference than in the positive transference because in her experience the negative transference tends to manifest more explicitly in the room than the positive transference.

In comparing her experience with a patient who R1 thinks has "a very positive transference" (R1, NMU 230, p. 82) towards her but with whom she cannot easily interpret or work in the transference, R1 describes her work with a patient with a similar background but who demonstrates "very negative transference feelings" (R1, NMU 232, p. 82) which come alive in the room "with her it does" (R1, NMU 238, p. 82) and with whom as a result R1 "works in the transference a lot" (R1, NMU 228, p. 82). In this regard R1 says for example that,

> …other people come with a similar sort of background…I have another patient who I work very much in the transference…it's interesting it might be about the negative transference…it's a very negative transference…it's all about not feeling safe…[and yet it never comes alive in the room?]…no with her it does, that's what I'm saying…I'm wondering if it's easier to work in the negative transference than it is much more in the positive transference (R1, NMU 227 – 239, p. 82).

Like R1, R3 describes interpreting or working in what appears to be the negative transference in the hope of removing it to restore her patient's trust in her. In describing her work with a particular patient who generally demonstrates very positive transference feelings towards her, R3 says for example that,

> …then when that goes wrong because now she feels I can't be trusted anymore or I've said something that has upset her, that's when I make a transference interpretation, the rest of the time I'm listening (R3, NMU 191 – 205, p. 120).

In terms of the positive transference both R1 and R3 report greater difficulty in interpreting or working in the positive transference. Drawing on her experience with the patient mentioned earlier who according to R1 experiences the therapy as a "very… safe place" (R1, NMU 230, p. 82) and whom R1 thinks has "a very positive transference with me" (R1, NMU 230, p. 82) she says for example that,

> …he can't go there yet…it's partly a way of keeping distant…even if I was to make comments about how important our relationship is, he wouldn't acknowledge that…I don't think that's moving the therapy much (R1, NMU 242 – 243, p. 82).

This particular patient also rejects any effort on the part of R1 to work in what might seem like the presence of the negative transference. R1 says for example that,

> I once made a transference comment about which I thought was the start of a negative transference…he just said that he feels I understand him like no one's understood him and I give words to his experience…he just said absolutely that I was wrong in what I …and quite upset that I could even think that (R1, NMU 380 – 385, p. 85).

R1 attributes her patient's resistance to her efforts at interpreting or working in the transference to his need to experience her as a benign figure. She says in this regard that,

> …to this day I do try and make transference comments with him…I somehow think he's not…at the moment I think I'm a very good figure for him…he needs to keep me good…(R1, NMU 356 – 359, p. 84)

Like R1's patient who resists her efforts in interpreting/working in the transference, there are also patients in R3's practice who she thinks resist or ignore her efforts in working in the transference because they need to experience and perceive her as a benign object. R3 says for example that,

> …I've got another person who doesn't really allow me to work in the transference, but I do feel good work is being done…my idea is that she needs to idealize me…she cannot bear the thought that anything is wrong with me…she can't bear anything negative…if there's something negative then she mistrusts completely (R3, NMU 209 – 233, p. 120)

According to R3, interpreting or working in the positive transference more generally speaking is considered unnecessary because in the positive transference, the patient's experience of both the setting as a safe place and the therapist as a benign figure is intact. She says for example that,

> There are many moments in all therapies where you're not specifically working in the transference and you don't need to at that moment, because they've achieved a place where they feel they are actually able to be free (R3, NMU 766 – 786, p. 133)

At times like this, she says that, "they feel comfortable with you as someone who is genuinely interested in them" (R3, NMU 759, p. 132). For R3, this is a "depressive position moment" (R3, NMU 761, p. 132). According to R3, when patients are functioning in the depressive position they "can be themselves and actually go into themselves and free associate in quite a genuine way because they're free to" (R3, NMU 764, p. 132).

R1 makes a similar point. According to her, interpreting or working in the transference is not indicated when doing so interrupts the patient in the process of associating or forecloses on the patient's production of fresh material. Drawing on her own experience as a patient, R1 says for example that,

> …Just in terms of my own experience, sometimes I've spoken about things and it's been linked, it's been understood in the transference, which I can see it seems like a fit but that's actually stunted the exploration of what I need to explore…it hasn't taken it further…it's actually foreclosed on something (R1, NMU 758 – 763, p. 93).

It is generally not indicated to interpret or work in the positive transference across both R1 and R3 because the positive transference does not manifest explicitly in the room as a resistance to the process. The kinds of patients described by both R1 and R3 resist their efforts in interpreting or working in the positive transference because these patients need to experience the therapist as a benign figure and the setting as a safe place.

Interpreting or working in the positive transference is not indicated in both R1 and R3's experience because positive transference relations appear to promote the therapeutic process.

It is interesting to note from close analysis of R4's interview that while interpreting or working in the transference is not a central focus in her predominantly supportive oriented practice, like therapists R1 and R3, she indicates the importance of addressing transference material when it manifests as a resistance to the therapeutic process and "contaminates" the therapeutic relationship.

In this regard, R4 indicates the centrality of addressing idealizing/negative transference material in order to remove the transference, restore therapeutic relations and promote the therapeutic process.

> My focus on the transference is more when the negative transference emerges or when idealizing transference emerge, then I will work hard to understand them (R4, NMU 68, p. 139)…I think it's only when it gets in the way that you need to analyse it…I think that's when I mostly analyse it, but it isn't my theoretical focus…it's not what I'm holding in mind…(R4, NMU 653 – 654, p. 152).

Like R1 and R3, R4 also does not interpret the positive transference when the therapeutic process appears to be in progress. She says for example that,

> There have been clients where I've felt that they have felt positive towards me, but I haven't use the transference, I haven't commented on it, I haven't interpreted, I've just worked in it…(R4, NMU 168, p. 141).

This theme did not emerge explicitly in R2's interview.

4.2.4 <u>The centrality of interpreting/working in EXPLICIT NEGATIVE transference material - A function of HOW the transference is treated and interpreted or worked in.</u>

Close analysis of R1's work indicates the centrality of interpreting or working in the negative transference as a function of HOW the negative transference material is interpreted or worked in. In this regard R1 emphasises the importance of first understanding the transference objectively allowing it to pass as real in the so-called here-and-now before making any genetic links – that is before treating it transferentially by attributing it, or tracing it back, to another/object in the past.

> …it's kind of dealing with it in the here-and-now…trying to make sense of it and then linking it, sometimes not necessarily at [the same] time because it often can feel that it takes away or its trying to avoid actually what's going on between us…(R1, NMU 464 – 467, p. 87)

In working in the here-and-now of the negative transference, R1 indicates the role of her countertransference both as a potential hindrance **and** as a key tool in understanding her patient's explicit negative transference feelings objectively. R1 also shows that she is able to remove the patient's explicit negative transference by keeping her countertransference in check precisely by using it in understanding her patient's negative transference feelings objectively from her patient's perspective and in formulating an interpretation that mirrors her patient's negative feelings and reflects her (R1's) empathic understanding in the here-and-now.

Drawing on a recent experience R1 says for example that,

> Like this morning for example…this patient…she's gotten so in touch with her deprivation that she feels that she doesn't have a place with me…she asked for another session next week because she's going to miss her Monday session…it can only be on two other days that I can give it to her because she comes three times a week…she pushed me…*will I be able to!* …now on those two days I'm actually full but with the long weekend usually some people are away so the likelihood is I probably can fit her in somewhere…I felt so irritated…my countertransference…I used it because I said *it feels that you've got to fight* you know because it felt like pinning me down and putting me on the spot…I can't say *yes I've got time for you* …I suppose it's the countertransference…I just felt like I haven't got any…but it was to think why…it was that sense of feeling pinned down and pushed and fight…I mean it's her feeling…I said to her that she's got to fight to get a place…that somehow she feels she's got to fight to get in, which she acknowledged (R1, NMU 423 – 501, p. 86).

It is interesting to note that by using her countertransference to understand and account for her patient' s negative transference material objectively in the here-and-now, R1 not only keeps her countertransference in check, but in doing so maintains technical neutrality by meeting her patient's ego needs interpretively.

Like R1, R4 indicates the importance of understanding and treating her client's negative transference material objectively in the here-and-now. However, while R1 does so by meeting her patient' s implicit ego need with interpretations that mirror her patient's feelings and reflect her empathic understanding of them, R4 does so by accounting for her inevitable empathic failure to meet her client's implicit ego needs.

> …the idealizing transferences are resistances to the process that's why I'm alert to those…I will comment, but I tend not to comment so much…I mean it's interesting because when clients have idealizing transferences often it's about narcissism and often then you don't want to humiliate because…like very much the self psychology, the influence of Kohut where you work with the inevitable empathic failure and that's what you work with…(R4, NMU 671 – 679, p. 152).

In contrast to R1, who removes her patient's negative transference and restores positive therapeutic relations by keeping her countertransference in check paradoxically by using it in understanding her patient's negative transference material objectively and in formulating an interpretation that meets her patient's implicit ego needs empathically, R4 does so by keeping her countertransference in check by meeting her client's implicit ego needs paradoxically by accounting for her empathic failure to do so instead.

> …you hold in mind the idealizing transference and you know it when there's an inevitable failure and what's that like, what was it like for you that I didn't…it must have been difficult or I wonder what it was like for you that I didn't understand…I might explore that with them or I might link it to say that you know the history…you've never felt that people have understood you and a mother who couldn't hold you, she was physically unable to hold you…she was ill…or whatever…I mean it's like when that experiences emerges again and I couldn't understand or I couldn't help you or I wasn't able to take that crisis call that you…whatever it is…(R4, NMU 681 – 688, p. 153).

4.2.5 <u>The centrality of interpreting/working in the transference - A function of the clarity of the countertransference.</u>

According to therapist R2 the centrality of treating and interpreting explicit transference material objectively in the here-and-now before treating and interpreting it as transference emerges as a function of the **clarity** of the countertransference. In other words, for R2, the extent to which the countertransference can be kept in check by using it in understanding the patient's transference material objectively and in formulating interpretations that meet the patient's implicit ego needs interpretively depends on the clarity of the countertransference.

In this regard, close analysis of R2's work shows that the clarity of the countertransference emerges as a function of the status of the integrity of the patient's ego where as a general rule the more intact that patient's ego the clearer the countertransference and hence the more readily it can be kept in check by using it in understanding the patient's material objectively and in formulating interpretations reflective of the patient's transference material and the therapist's empathic understanding thereof. R2 says in this regard that,

> …It's much easier for me with a person who has got a strong ego functioning to sort out my own countertransference…by doing so, giving…reflecting it back (R2, NMU 598 -600, p. 108).

While the clarity of the countertransference emerges as a function of the patient's developmental status, it is interesting to note from close reading of R2's work with a more neurotic patient that the transference appears to manifest as a resistance to the therapeutic process in the form of the erotic positive transference. In this regard, R2 says for example that,

> …I think with a neurotic patient…it was quite easy to know where I was…I could give words…it was easy to reformulate it in a way that would be helpful to him…I knew this because he is in love with his mother and he is terrified of being in love with me or he turns the thing around and makes it active…it brings up my own sexual feelings…it was easy to reformulate it in a way that would be helpful to him…so there is a very easy translation from the countertransference feeling into words (R2, NMU 247 – 261, p. 100).

In keeping with the general idea that the clarity of the countertransference emerges as a function of the status of the integrity of the patient's ego where the more developed the patient the clearer the countertransference and where the more disturbed the patient the less clear the countertransference, close reading of R2's work with a more fragile patient shows that the transference appears to manifest as a resistance to the therapeutic process in the form of the negative transference.

> …whereas with a more fragile patient, you need more time to yourself to first sort it out in yourself…which layers of your own self are attacked or so addressed so that at least in future sessions you can use that…(R2, NMU 607, p. 108).

In contrast to R1 and R3 in whose practice the transference tends to manifest explicitly more commonly as a resistance to the therapeutic process in the form of the negative transference, in R2's experience, the transference can manifest explicitly as a resistance to the therapeutic process in the form of the positive erotic and the negative transference.

On the basis of close reading of R2's work, it seems suggested that like the clarity of the countertransference, the affective nature of how the transference manifests explicitly as a resistance to the therapeutic process emerges as a function of the patient's developmental status where as a general rule the more developed the patient, the greater the tendency towards the positive erotic transference resistance and where the more disturbed the patient, the greater the tendency towards the negative transference resistance. (NB, this does not mean that the negative transference cannot and does not manifest as a resistance to the process among more psychologically developed patients)

In so far as both the clarity of the countertransference and the affective nature of the transference resistance emerge as a function of the patient's developmental status, for R2 it is generally considered more appropriate to interpret or work in the positive erotic transference resistance among psychologically developed patients **because** the countertransference experience among these kinds of patients tends to be clear and therefore more readily kept in check by using it in formulating interpretations of the positive erotic transference material in a way that removes it as a resistance to the therapeutic process interpretively.

In terms of the negative transference, in contrast to R1 for whom the centrality of interpreting or working in the negative transference **irrespective** of the patient's developmental status emerges as a function of the extent to which the countertransference can be kept in check by using it in formulating interpretations of the patient's material that mirror the patient's feelings and in so doing meet the patient's implicit ego needs

empathically, according to R2 interpreting or working in the negative transference among more psychologically disturbed patients is generally **not** indicated precisely because among more disturbed patients, the countertransference experience tends to be less clear, more difficult to sort out and for this reason cannot be immediately used in understanding the patient's negative transference objectively and in formulating interpretations that meet the patient's implicit ego needs empathically by mirroring the patient's feeling and reflecting the therapist understanding.

In further support of the idea that the clarity of the countertransference emerges as a function of the status of the integrity of the patient's ego, according to R2 it is the countertransference experience in relation to the more psychologically disturbed patient that leaves her in a more vulnerable and anxious state. In this regard, R2 says for example that,

> …I feel more solid of course with a more neurotic patient…I mean less ill patient who has less pre-oedipal issues…I feel more solid…if I make a mistake it is not such a big thing…it's much more reasonable…it can be much more intense with more…in a way much bigger…there can be big intensity with a neurotic one as well…because I'm dealing with things that are more easily known to me…anxiety doesn't come up so much whereas with a patient who is very disturbed, my anxiety or my vulnerability is of course much bigger…I end up in a much more vulnerable state (R2, NMU 636 – 643, p. 109).

By implication among more disturbed patients with whom the transference tends to manifest explicitly as a resistance to the therapeutic process more commonly in the form of the negative transference, it is generally not indicated to interpret or work in the negative transference resistance precisely because the countertransference experience leaves the therapist in a more vulnerable and anxious state and therefore less likely able to keep it in check by using it in understanding the patient's material objectively and in removing the negative transference resistance with interpretations that meet the patient's implicit ego needs interpretively.

In so far as the clarity of the countertransference emerges as a function of the patient's developmental status, it is interesting to note in this regard that the clarity of the

countertransference across all the therapists also emerges as a function of whether or not the patient relates to the therapist as a figure from the past or as a projected part of him/herself.

According to therapist R2 in particular, the countertransference is generally considered more difficult to sort out when the patient is relating to the therapist as a projected part of him/herself than when the patient is relating to the therapist as a whole figure from the past and often requires analysis before using it in interpreting or working in the transference in the here-and-now. As a general rule it is not indicated to interpret or work in projected transference material because the countertransference tends to be less clear.

> …it's often something that I think is very difficult to address particularly at such a stage when it's happening, certainly early in the therapy…if it can't be expressed then I think it's something that first of all needs to be worked through in the therapist…(R2, NMU 146 – 148, p. 98).

In so far as the clarity of the countertransference emerges both as a function of the patient's developmental status and whether the patient relates to the therapist as a projected part of him/herself or as a separate figure from the past, it is not as a general rule indicated to interpret or work in the negative transference among more psychologically disturbed patients because the countertransference tends to be less clear when the patient relates to the therapist as a projected part of him/herself.

In situations where the countertransference is unclear and therefore cannot be kept in check by using it in understanding the more psychologically disturbed patient's negative transference material objectively and in formulating interpretations that remove it as a resistance to the therapeutic process by mirroring the patient's feelings and the therapist's empathic understanding of it as a protest against feeling unsafe – that is, by meeting the patient's implicit ego needs empathically, R2 suggests the importance of countertransference analysis.

According to R2 it is important to wait for clarity in the countertransference experience before it is indicated to interpret or work in the psychologically disturbed patient's negative transference. In this regard, countertransference analysis emerges as an important guide in determining **when** it is indicated to remove the negative transference as a resistance to the therapeutic process among more psychologically disturbed patients interpretively. Countertransference analysis and the clarity of the countertransference play a central role in **timing** interpretations of the negative transference resistance among more psychologically disturbed patients.

4.3 On practicing psychoanalytic psychotherapy in the absence of explicit transference manifestations.

4.3.1 The kinds of patients described

In contrast to the kinds of patients described by the therapists in this study who demonstrate explicitly positive or negative transference feelings, the participating therapists describe a certain group or type of patient who demonstrates neither directly verbal nor affectively intense (either positive or negative) references to the therapist.

While presenting as seemingly functional occupationally, the patient's described by the therapists in this study demonstrate failed capacities for object relating evident both in relation to significant others and in the transference. This aspect of these patients' functioning seems to betray an underlying area of their personalities that is split off, inaccessible from contact and manifest in a seeming absence of explicit transference.

In presenting with the kind of pathology that seems to place them outside the reach of the therapeutic relationship, it is these kinds of patients who call into question the centrality of interpreting or working in the transference as a major vehicle in effecting what can be called unconscious or intrapsychic work and raise the paradoxical question for psychoanalytic psychotherapists on how to practice their craft in the seeming absence of the tool that defines and distinguishes what they do in the room as psychoanalytic.

In talking about her clinical experience, and thoughts about, working in the absence of explicit transference manifestations, R1 for example describes a patient who while functional occupationally seemed to be out of touch with himself emotionally.

> …I think for example it is a character style…quite an out-of-touch sort of man…a good boy…he's done well in his profession…but he hasn't given much thought to himself…I suppose that's what therapy is going to be about (R1, NMU 159 – 164, p. 80).

According to R1 this particular patient presented in therapy with overwhelming feelings of anxiety that impacted on his capacity to think and establish emotionally meaningful interpersonal contact. R1 says for example that,

> …When he came, he would come in and he'd say it's chaotic…he couldn't…that's all he'd say…if I never said anything he wouldn't say anything more (R1, NMU 258 –261, p. 82).

In describing her patient's failed capacity for object relating seemingly manifest in an absence of explicit transference, R1 says for example that,

> …I don't really have a sense of what his relationship is with me…I know I'm important to him but I don't get that…I know it in my head, I don't feel it…(R1, NMU 362 – 366, p. 82).

According to R1 this patient merely tolerated her attempts at making transference interpretations. She says for example that,

> …Occasionally I do make transference interpretations which he never ever picks up on…he's a man with so much anxiety that what he brings…it's only about work…I think he tolerates it when I make transference interpretations (R1, NMU 185 – 190, p. 81).

Like R1, R2 describes a patient incapable of authentic object relating and with whom she does not as a result experience real emotionally meaningful contact. She says for example that,

> …He was a real conman with that smooth voice…he was forever talking about that he wants to know the truth but what he spoke about was so empty…so devoid of anything (R2, NMU 378 – 382, p. 103)…this smooth voice and always being so nice to me…it felt pseudo…it was dreadful…(R2, NMU 388 -392, p. 103).

According to R2 her patient avoided the transference connection by falling asleep. She says for example that,

> …To face the affect towards me…although it doesn't come up in the session, it only comes up in my mind…it could be linked to that [a defence] because he cannot and he doesn't and I have only on a theoretical level addressed…I mean not on a very direct level, rather in terms of just talking about it…mentioned that he finds it difficult to relay anything of how he thinks or feels about me (R2, NMU 459 – 466, p. 105)

For R2, interpreting or working in the transference with this particular patient would be "close to unthinkable"(R2, NMU 84, p. 96). She says for example that,

> …He is in psychodynamic therapy…he comes twice a week…the transference interpretations have been minimal, absolutely minimal…this will remain so because it terrifies the patient, it absolutely terrifies the patient and he will have nothing to do with it…he is certainly not in a state where he would be able to be conscious about it (R2, NMU 83 – 92, p. 96).

In talking about her experience of working in the absence of explicit transference manifestations, R3 describes a "very adhesive" patient who could only pretend how to be human because she did not know how to have an authentic relationship. According to R3 this patient could not take in anything… "it would kind of slide off" (R3, NMU 336, p. 123). R3 likened this to the concept of "adhesive identification"(Meltzer 1975).

> ...She keeps herself in a state that she's incapable of taking anything in…I actually despaired quite a lot about how I was ever going to help her because she couldn't take in any interpretations…she couldn't take in anything…it would kind of fall off…she couldn't get in touch…she's very adhesive…I don't know if you know the concept of "adhesive identification"…it's like she doesn't know how to have a proper relationship…she only knew how to pretend to be a human (R3, NMU 332 – 343, p. 123).

Another patient who R3 describes in her experience of working in the seeming absence of explicit transference presented in treatment as seemingly functional but who according to R3 was actually "quite disturbed". The transference with this patient did not manifest explicitly in the room because of her patient's profound emotional splitting.

> …She's sort of eradicated every feeling she's ever had to the point that she hasn't been able to have relationships at all…she hasn't been able to get herself a career that actually matters to her…everything's meaningless…it's because she cuts off every feeling before it can develop into anything (R3, NMU 242- 245, p. 121).

R3's patient's failed capacity for authentic object relating manifest in a seeming absence of explicit transference meant for R3 that, "it was very difficult in the beginning for me to even think about it…to even think that there was even such a thing as transference (R3, NMU 492 – 495, p. 126).

Commenting further on the seeming absent transference with her patient R3 says that,

> …I couldn't even think there was such a thing as transference because she didn't want to have a relationship with me…she was too frightened…she doesn't want to feel anything for me…she doesn't want to be dependent on me (R3, NMU 509 – 513, p. 127).

Drawing on her experience while working within an Object Relations orientation, R4 describes a very defended patient who had split off parts of his personality and who had rendered himself "invisible" as a result.

> …I do think he was very defended…he was a client who had split off enormous aspects of himself and kept himself hidden from people around him and hid his sexuality for many years…I do think it was about being invisible…I think he was being invisible to himself and to everyone around him and not allowing himself…(R4, NMU 218 – 225, p. 142).

In describing the seeming absent transference with her very defended patient, R4 says that,

> …there wasn't like a positive transference to me…there wasn't a negative…I didn't feel like anybody in his life (R4, NMU 166, p. 141).

For R4, her client's seemingly absent transference "was about being invisible". She says further that, "in DSM terms he was quite a schizoid or maybe more avoidant…(R4, NMU 230, p. 142). Also, rather than experience any directly verbal or affectively intense feelings towards her, R4 felt that her client related to her mechanically and purely as a professional.

> …I think it was very much I'm the professional…he was wary, he was unsure…it was like a mechanical feeling…he was like dutiful, he came because it was good for him…I didn't feel really connected to him (R4, NMU 752 – 756, p. 154).

It is interesting to note that while an absence of explicit transference manifestations can be a function of both the frequency of weekly sessions as well as the patient's underlying pathology, it seems that an absence of explicit transference among the kinds of patients described by the therapists emerges predominantly as a function of their underlying psychopathology and in particular of their developmental status as pre-oedipal.

In this regard, R3 specifically attributes an absence of explicit transference among the two patients that she describes to their developmental status, which she implies as being pre-oedipal.

An absence of explicit transference manifestations emerges as diagnostic of the patient's pre-oedipal developmental status and signals both the nature of the kind of work required and the therapeutic role to be assumed in doing so.

4.3.2 Therapeutic aims in the absence of explicit transference manifestations

Among the kinds of patients described in this study who to varying degrees demonstrate failed capacities for establishing emotionally meaningful contact, a key goal is to bring them into contact with split off and projected emotional material. The aims in the

absence of explicit transference manifestations include ego building, developmental or foundational work.

In so far as the therapists aim to foster greater self-awareness, empathy and understanding in their patients, emphasis is placed on providing a new kind of relationship conducive to the development of integrated ego functioning and a capacity for establishing and sustaining close and emotionally meaningful interpersonal relationships.

It is in this regard that all the therapists indicate doing developmental or foundational work. For therapists R1, R2 and R3, this kind of work is also aimed at 'preparing the ground' for interpreting or working in the transference.

4.4 Therapeutic action and techniques for effecting developmental work in the absence of explicit transference manifestations.

4.4.1 Establishing the setting as a safe place and functioning as a benign figure.

In the absence of explicit transference manifestations close analysis across all the interviews reveals a shift in emphasis from the centrality of interpreting or working in the transference in the classical sense of making the unconscious conscious to the importance of establishing the therapeutic setting as a safe environment conducive to the development of integrated ego functioning and a capacity to become conscious of the unconscious (i.e., ego building and strengthening).

Among the kinds of patients who show no directly verbal or affectively intense transference feelings, emphasis across all the therapists appears placed on establishing the patient's experience of the therapist as a benign figure and in fostering positive therapeutic relations over and above immediately interpreting or working in the transference.

For example, with her very anxious patient who merely tolerates her efforts at interpreting the transference, R1 refers to the importance of therapeutic setting as "a place where there's something to hold onto a part of himself and where he can get through a situation knowing that he can come here and talk about it (R1, NMU 210 –211, p. 81).

She also refers to the containing function of the therapeutic setting as "a space to think. R1 says that her patient's "sense of being in therapy has been incredibly containing for him…in having a space where he's internalised…a space to think…that it is possible to think about intolerable feelings" (R1, NMU 301 – 307, p. 83).

In relation to the patient R2 describes as a "conman" and with whom interpreting or working in the transference according to her is "close to unthinkable", R2 describes the therapeutic setting as "the womb…a space where certainly with these patients…a space where they can sit and be free…and where they can be relatively safe…I mean it is a thinking place after all (R2, NMU 679, p. 110).

Both generally and in the absence of explicit transference manifestations, R3 indicates the importance of the therapeutic setting as a safe environment and her patients' experience of her as benign figure over working in the transference specifically. According to R3,

> …There are many moments and I think there are many moments in all therapies where you're not specifically working in the transference and you don't need to at that moment because they've achieved a place where they feel they are actually able to be free…they're actually free to associate because they are free and they don't expect you to be judging them…they're experiencing you as someone who is just what you are, someone who is just genuinely interested and is non-judgmental. (R3, NMU 790 – 796, p. 133)

Across all the therapists three therapeutic techniques stand out as key in establishing the setting as a safe environment and in functioning as a benign figure when working in the absence of explicit transference manifestations. These are, 1) working with the 'other'

(not specifically transferential) material the patient brings to therapy; 2) containing; and 3) maintaining technical neutrality.

4.4.2 Working with the 'other' material the patient brings as non-transference

In the absence of explicit transference manifestations, instead of directly interpreting or working in the transference, all the therapists seem to focus on exploring and making sense of the material that their respective patients bring to therapy. Most often, this material does not pertain explicitly to the transference.

For R1, 'non-transference' material essentially stems from 'outside' the room and includes historical data, the nature of the patient's anxieties and defences, interpersonal relationships and work related issues.

> …One still makes interpretations about where the patient might be coming from…I suppose it's just not done within the relationship…I suppose a lot of it would be about exploring what the person brings which invariably entails exploring their history…(R1, NMU 143 – 145, p. 80)…I think a huge part is also exploring on who the person is, their anxieties, their defences, their psychological makeup (R1, NMU 647, p. 91).

R2 states explicitly in this regard that, "I would speak with them about something that happens outside the room" (R2, NMU 126, p. 97). For R2, the analysis and interpretation of extra-transference material can also have a "powerful impact". She says for example that,

> …If there is a transference happening towards another person that is linked say with his mother or father…that is happening outside the room, that also can have a very very strong impact (R2, NMU 128 – 131, p. 97).

Both R1 and R4 mention the role of linking past and present experiences of material that stem from outside the room. Linking appears to be another means by which the therapists attempt to make sense of their patients' material and in doing so function as an auxiliary ego.

Drawing on her clinical experience with her very anxious patient with whom she does not experience a transference connection, R1 says for example that,

> …I suppose the technique would be to be making links with current behaviour, with past behaviour…and then the only thing he doesn't have is the transference link (R1, NMU 213, p. 81).

According to R4 for whom interpreting or working in the transference is not a central focus in her practice and without specifically drawing on her experience with a particular client in mind, R4 says more generally in this regard that,

> …I don't use CBT techniques, but sometimes certainly with some clients I've helped them use their intellect to understand…understanding, making links between past and present, understanding, pointing out, clarifying for people…(R4, NMU 391 – 394, p. 146).

Both R1 and R4 acknowledge the role of linking in building the patient's ego functioning and in fostering greater self-awareness and understanding. R4 highlights how new areas to explore are often also triggered or opened up in this way. For her, reframing is an additional means of forming new links for her clients. It is in this sense that linking emerges as playing an important role in facilitating the production of fresh clinical material without specifically interpreting or working in the transference. In this regard, R4 says for example that,

> …Reframe…I'll often reframe things, so often make new connections for clients that they haven't ever thought about, they've never seen things in that way (R4, NMU 398, p.146)

Additional clinical material that therapists R1, R2 and R3 appear to focus on in the absence of explicit transference manifestations is the therapeutic process itself. The process of how the patient uses (or fails to use) the therapeutic space emerges across all the interviews as an important part of what the therapists observe and feed back to the patient in the form of what might be called process comments. In doing so the therapists also position themselves to function for their patients as an observing ego. As

demonstrated by R2, process comments need not necessarily be limited to an exclusive focus on the patient.

Drawing on her experience in working in the absence of explicit transference manifestations with the patient she describes as a 'conman' and with whom there was "endlessly non-verbal things" (R2, NMU, 423), R2 describes how she was able to comment on the therapeutic process in terms of her tendency to fall asleep during his sessions rather than specifically interpret this in terms of the transference. She says for example that,

> …There was a time where I regularly feel asleep in his session…that aggravated him very much…I could give back to him that this is something that shouldn't happen but that we should look at it…(R2, NMU 221 – 223, p. 99).

In working in the absence of explicit transference with her emotionally "out of touch" patient, R1 says for example that,

> …A lot of time is being spent just noticing how he's so vigilant to other people's feelings, he isn't to his own…(R1, NMU 525, p. 88)

Speaking more generally about the importance of process comments before interpreting the transference, R1, for example, highlights the role of process comments in facilitating the patient's capacity to begin thinking about him/herself.

> …Then you comment on the process, what's happening…often that does lead to more transference sort of things…the person can really start thinking why are they telling you this story and there's no feeling…then it's about why are they so cut off (R1, NMU 652 – 658, p. 91).

According to R1, while process comments are not strictly examples of working in the transference, they play an important role in leading up to interpreting the transference.

> …That's not really working in the transference…the effect is that the person thinks about themselves…it forces also to think about themselves in a relationship that's why I say it often leads on to transference because then they also become

> aware of this relationship and then often are more amenable to transference interpretations… (R1, NMU 659 – 667, p. 91)

For R1, process comments often precede, and "prepare the ground" for, the centrality of interpreting or working in the transference. She says that,

> …I think if you just make a transference interpretation out of the blue, I think the person can think you're quite crazy and I think it's counterproductive…with some patients it's almost preparing the ground to make more transference interpretations …obviously if it comes, if a patient says I'm so furious with the comment you made or it's that direct transference…the more indirect transference, I think you prepare the way for. (R1, NMU 670 – 676, p. 91).

In the absence of explicit transference, R3 emphasises the role of process comments over directly working in the transference in both drawing attention to, and in accessing the content of the emotions her patients struggle to express.

> …Mainly I listen and wait, I might make an interpretation that would comment on their not seeming to express what they're feeling in order to get to what the feeling is (R3, NMU 141 –144, p. 119).

Drawing more specifically on her experience in working with her patient who has eradicated her feelings, R3 says that,

> …When there's been a little bit of feeling, I've tried to focus on it…I've tried to bring it…I mean she'll get there and immediately move…I'll try and bring her back…I've done it a little bit (R3, NMU 254 – 258, p. 121)…I've interpreted a lot about her not being able to feel her feelings (R3, NMU 271, p. 121).

In relation to her "very adhesive patient" who "had no clue what she was about" (R3, NMU 372, p. 124), R3 describes the role of process comments rather than interpreting the transference. She says for example that,

> …A lot of interpretations about what was happening…about how she seemed to feel she had to copy what I was telling her or she had to memorise it (R3, NMU 411 - 412, p. 125).

While the role of process comments did not specifically emerge in relation to R4's experience of working with her patient in the absence of explicit transference, it's importance was implied in her supportive practice generally and in relation to the use of her countertransference in doing so. Drawing on her experience with a patient who did not seem to be in touch with her anger, R4 says for example that,

> …I was much more explicit that I was feeling angry while she was talking…I wondered where her anger was and what was that about that she couldn't be angry (R4, NMU 562 – 563, p. 150).

4.4.3 Containing implicit transference material

In the absence of explicit transference manifestations, the transference tends to manifest implicitly in the form of split off and projected emotional material. In this regard, therapists R1, R2 and R3 indicate the centrality of containing implicit transference material in order to understand, process and digest it objectively **first** over immediately treating and interpreting it as transference.

In other words, in the absence of explicit transference manifestations, the therapists emphasise the importance of containing spit off and projected emotional material or what might be referred to as implicit transference manifestations before directly interpreting or working in it in the classic sense of making the unconscious conscious by tracing or attributing it to an/other object in the past. Interpreting or working in the transference as transference irrespective of how it manifests, is not a primary focus in R4's predominantly supportive practice.

In emphasising the importance of containing implicit transference material before interpreting or working in it as transference, the therapists not only appear to position themselves to receive and understand the patient's implicit transference material objectively as a form of unconscious communication, but in doing so, facilitate the establishment of the setting as a safe environment in which their patients can feel contained and understood empathically. In this regard, R4 points to the containing

effects of establishing the setting as a safe environment and in functioning as a consistent, benign figure.

With her "very anxious" patient for example, R1 emphasises containing his implicit transference material as an unconscious communication to understand and process empathically rather than interpret or work in it as transference. She says that,

> …In some ways that what he gives me, I can take in and work out…(R1, NMU 318 – 320, p. 84).

For R1 containing her patient's implicit transference material rather than treating and interpreting it as transference plays an important role in establishing the setting as a safe place and facilitates the internalisation process important in building the patient's ego and capacity to think – that is, to become conscious of the unconscious.

As mentioned before, R1 says in this regard that,

> …I think that's where the therapy has certainly helped him and still helps him…there's something to hold onto a part of himself where he can get through a situation knowing that he can come here and talk about it…(R1, NMU 210 – 211, p. 81)…I think in having a space which I think he's internalised…a space to think about what's…that it is possible to think about intolerable feelings (R1, NMU 306 – 307, p. 83).

R2 also emphasises containing implicit transference material over immediately treating and interpreting it as transference. For her, containing plays an important role in processing and digesting her patient's implicit transference material empathically and in doing so, also demonstrates her function as a benign figure.

> …Precisely my not talking…my not talking about how he makes me feel was very important…my taking it in my taking everything from him and being able for some unknown reason to tolerate the enormous anxiety…and kind of digest it again and again and again. (R2, NMU 204 – 210, p. 99)

According to R2, containing implicit transference material often precedes the centrality of interpreting it as transference in the classical sense of making the unconscious conscious by tracing/attributing it to an/other object in the past. Containing for R2 also appears to play an important role in timing interpretations of the implicit transference that give back in words the patient's split off and projected emotional material - that make implicit transference material verbally explicit to the patient.

> …I stayed with anxiety for many months until it became less…it was still many months before I could actually give it back to him…(R2, NMU 212 – 214, p. 99)

With the patient who "eradicates" her feelings and avoids feeling anything towards R3 because she does not want to have a relationship with her, R3 also mentions the role of containing and waiting before immediately interpreting, or working in, her patient's material as transference.

> …I don't feel that saying that will get her there…I feel I have to wait…I actually have to have it in me and wait, and then at some point in the session or it might only be in the next session she does get to it…I don't feel if I said it, it would get her there it's as if she can't at that point (R3, NMU 156 – 161, p. 119).

While R4 does not focus on interpreting or working in the transference generally, she emphasises her role as a consistent figure in establishing the therapeutic setting as a containing environment in which her client feels safe to begin exploring sensitive material that otherwise makes him want to be invisible to himself and others. She says for example that,

> …I was prepared to be there and that I listened… it was the relationship I was able to be consistent…he's felt contained…I didn't let him fall…I didn't humiliate him…I didn't make him feel ashamed…he didn't want to die in the process of telling me things he felt ashamed of…what that meant is that we could play together…he could trust the space between us (R4, NMU 770-807, p. 155)

It is interesting to note that while therapists R1, R2 and R3 specifically mention the role of containing in establishing the setting as a safe environment over immediately

interpreting or working in the patient's implicit transference as transference, R4 suggests the containing effects of functioning as a consistent, benign figure and in establishing the therapeutic setting as a safe place.

4.4.4 Maintaining technical neutrality in the absence of explicit transference manifestations

Close analysis of the interviews shows that in the absence of explicit transference manifestations, technical neutrality emerges as playing a central role in establishing the setting as a safe environment and in fostering the patient's perception and experience of the therapist as a benign empathic figure.

It is the maintenance of technical neutrality over the centrality of interpreting or working in the patient's material as transference that establishes the kind of setting conducive to the development and strengthening of the integrity of the patient's ego and capacity to become conscious of the unconscious.

In this regard, it is interesting to note that containing split off and projected unconscious emotional material – that is implicit transference manifestations, emerges as a key means by which the therapists maintain technical neutrality in the absence of explicit transference among the particular kinds of patients they describe.

Close analysis across interviews R1, R2 and R3 shows that in the absence of explicit transference manifestations, technical neutrality is maintained by assuming the role of a consistent empathic figure and in attempting to understand the patient's implicit transference material objectively **before** treating and interpreting it as transference.

For example, R2 demonstrates technical neutrality by assuming the role of a consistent, non-reactionary figure in relation to her patient who she describes as a "conman".

> …I was always there…him realizing that next session I was the same…this tremendous regularity and the refusal of turning the relationship into something

> he was used to outside…that is, perverse relationship (R2, NMU 297 – 299, p. 101).

Speaking more generally in this regard, R2 stresses the importance of maintaining technical neutrality in establishing a safe therapeutic setting so that her patients can feel relatively free to express themselves without being or feeling attacked and where they are not in a relationship that is known to them. She points to the therapeutic value of maintaining technical neutrality in providing her patients with a new kind of non-reactionary relationship experience with a real person that is not easily repeated in other settings.

> …They are free because they are free to express themselves…comparatively speaking, free to express themselves without being attacked and where they are not in a relationship that is known to them…it's a new type of relationship…there is something exceptional in any real therapeutic relationship that can't be so easily repeated anywhere else (R2, NMU 684 – 699, p. 110)

Like R2, R3 maintains technical neutrality with her patients who reject transference interpretations precisely by not interpreting or working in their material as transference at first and by assuming a non-reactionary empathic therapeutic role instead.

Drawing on her experience with her patient who does not want to have a relationship with her, R3 says for example that,

> …It's very hard to try and force someone to relate to you when you're going to be rejected…understanding that helps me to be able to not be that little baby whose mother couldn't relate to her and rather be a therapist who can sit (R3, NMU 664 - 668, p. 130)…I don't always use the information I have to make direct interpretations…(R3, NMU 674, p. 130)

Analysis of interviews R1, R2 and R3 shows how in assuming a non-reactionary empathic role these therapists position themselves to understand empathically and treat the patient's implicit transference material objectively as non-transference first, that is, **before** tracing or attributing it to an/other figure from the past.

For therapists R1, R2 and R3, maintaining technical neutrality in the absence of explicit transference therefore also emerges as playing an important role in 'preparing the ground' for interpreting or working in the patient's material as transference.

In this regard and in contrast to therapists R1, R2 and R3, therapist R4's emphasis on maintaining technical neutrality centres more exclusively on her function as a reparative object and in establishing the therapeutic setting as a safe environment in which her clients can feel contained and free to develop more integrated ego functioning. Since a focus on interpreting or working in the transference is not primary in her practice generally, her emphasis on maintaining technical neutrality is **not** centred on 'preparing the ground' for making the unconscious conscious in the classical sense of treating and interpreting her clients' material as transference proper.

Drawing more specifically on her experience in working in the absence of explicit transference with her client who rendered himself "invisible, R4 emphasises the importance of maintaining technical neutrality more exclusively on her function as a reparative object and in providing him with a corrective emotional experience. She says in this regard for example that,

> …I think I didn't judge him…I think the shift came that I understood…I understood what he'd assumed was a very aberrant move in terms of this relationship with this young man…I think that I gave him permission to have experienced that…he was very struck by the way I've understood it because I'd given him a way of understanding it…I think also that I had absolutely non-judgmental…I'm very Rogerian with him because he was so ashamed of who he was…(R4, NMU 239 – 248, p. 143).

In assuming a non-reactionary empathic role, all the participating therapists demonstrate how they maintain technical neutrality in the process of establishing the kind of therapeutic setting conducive to the development and strengthening of the patient's ego functioning and capacity for consciousness without treating and interpreting transference material as transference.

Close analysis of R2's work in this regard shows that containing plays an important role in maintaining technical neutrality precisely by not interpreting or working in the patient's material as transference. Containing the patient's implicit transference also plays a central role in understanding the patient's split and projected emotional material objectively first and in processing and digesting it **before** giving it back in words in a way that is devoid of anything attacking.

In this regard and drawing on her experience in working with her "conman" and in relation to whom she felt afraid without experiencing any direct threat from him, R2 says for example that,

> …I mean this thing of containing, digesting and de-poisoning and giving something back in a digested manner…particularly without all the id impulses…so if I'm terrified of him hurting me surely I'm not in a state to give any meaningful answer back until it is property digested…I can give it back as something that is devoid of anything attacking…truthfully to give it back to him so that he can think about it and understand it…(R2, NMU 352 – 358, p. 102).

In the absence of explicit transference manifestations, R1 maintains technical neutrality with her 'very anxious' patient who she describes as being "out of touch with his emotions" by giving back in words his feelings rather than in treating and interpreting them as transference. Understanding her patient' s material objectively first and in formulating interpretations that give back in words her patient's unarticulated feelings play an important role for R1 not only in maintaining technical neutrality but in doing the kind of work involved in developing/integrating and strengthening her patient's ego.

> …I mean this is a man who is so out of touch with his feelings so yes certainly a lot of time is being spent just noticing how he's so vigilant to other people's feelings…he isn't to his own…starting to give words to what he's feeling…starting to make him aware that he's not just this man who kind of goes along in life (R1, NMU 525 – 529, p. 88).

R1 also emphasises the role of giving words to experiences, naming and labelling as an important part of all therapies over immediately interpreting and working in the patient's material as transference. She acknowledges how in doing so, and, in particular, when

working in the absence of explicit transference with her "very anxious" patient, she is not only able to facilitate the development of his ego functioning but in particular his capacity to think about, process and integrate otherwise intolerable and split off feelings.

> …It's both that, its about giving words to feelings, to experiences, labelling, naming…I think it's an incredibly important part of therapy…(R1, NMU 563 – 564, p. 89).

Close analysis shows that R1 maintains technical neutrality by treating her patient's unarticulated emotional material objectively first and in formulating interpretations reflective of her empathic understanding of it before treating and interpreting it as transference. In this way R1 not only demonstrates her function as a benign empathic figure but in doing so how she also establishes the setting as a safe environment interpretively.

It is interesting to note in this regard that in the absence of explicit transference manifestations, technical neutrality can be maintained both non-interpretively precisely by not treating or interpreting the patients material as transference, or interpretively by treating the patient's material objectively as non-transference in the form of giving back in words the patient's split off and projected/implicit transference material in a way that the patient can recognize and integrate as their own.

In the absence of explicit transference manifestations, the centrality of maintaining technical neutrality is emphasized over the centrality of interpreting or working in the patient's material as transference.

In establishing the setting as a safe environment and in fostering positive therapeutic relations, close analysis across all the interviews shows how the therapists appear to maintain technical neutrality by treating their patient's/client's split off and projected emotional material/ implicit transference objectively. In this regard, containing or formulating interpretations of split off and projected emotional material in ways that the patient can recognize and integrate as his/her own **before or without** attributing or

tracing it to the patient's relation to an/other figure in the past emerge as playing central roles in establishing the kind of therapeutic setting and relation to the therapist in which the development and strengthening of the integrity of the patient's ego can take place **without** resistance.

4.4.5 The centrality of countertransference analysis and interpretation in the absence of explicit transference manifestations.

Close phenomenological analysis across all the interviews shows that when the transference does not manifest explicitly in the room as a resistance to the therapeutic process, it tends to manifest implicitly (via projective mechanisms) in the therapists' countertransference experience in the form of an unconscious communication.

In this regard, among the kinds of patients whose psychopathology seems manifest in an absence of explicit transference, all the therapists describe affectively intense countertransference experiences that while incongruous with their usual therapeutic stance appear reflective of the patient's split off and projected emotional experiences.

R1 for example describes intense feelings of anxiety that appeared reflective of her "emotionally out-of-touch" patient's anxiety. She says for example that,

> …My countertransference came from the sense of anxiety…I felt terrible anxiety in those sessions…(R1, NMU 323, p. 84).

In R2's experience of working in the absence of explicit transference, she describes an incongruous reaction that appeared to mirror her patient's experience. R2 says in this regard that,

> …I can't really tell you…when I would fall asleep there was nothing that I could pin point other than I would fall asleep…I dreaded those Wednesday afternoon sessions…early afternoon I'm a bit low, but it doesn't mean that I automatically fall asleep…with him I would…it was over a period of time where he found it

> very difficult to come on a Wednesday…it would also happen to him that he would get into a trance whilst he was driving…he was falling asleep as well…(R2, NMU 423, p. 104).

Drawing on her experience in working with her patient who she describes as "very adhesive" and with whom the transference did not manifest explicitly in the room, like R1, R3 describes affectively intense countertransference feelings incongruous with her usual therapeutic stance and reflective of her patient's unconscious feelings about herself. R3 says for example that,

> …When she first came I hated her…I hated her… I thought she was, I mean I had the most terrible…the very first session I thought she was retarded which is not a word I would use normally even if someone was mentally disabled…I thought she was retarded and I thought she was common, like lower class which are not ideas I normally have about people either…but I mean that's actually what she feels about herself…that's what's emerged subsequently, but I felt it in the first session…(R3, NMU 300 – 310, p. 122).

Drawing on her experience in working in the absence of explicit transference with her patient who did not want to have a relationship with her, R3 also describes affectively intense countertransference feelings incongruous with her usual therapeutic stance. She says for example that,

> …I have quite intense countertransference with her…a lot of what I have had is I'm jealous…I'm jealous of the other people she has relationships with…it's because she won't with me…she has them with everybody else except with me…then I feel jealous…(R3, NMU 583 – 588, p. 128).

In describing her understanding of her patient's absent transference and corresponding countertransference experience, R3 says further that,

> …So her refusal to have a relationship with me is not only a fear of the transference which I think it is, it is also she's projected into me the experience that your object won't have a relationship with you, which is what her experience was with her mother…her mother was too depressed to relate to her, so that's what I'm doing…(R3, NMU 595 – 599, p. 129).

In R4's experience of working in the absence of explicit transference with her client who split off parts of his personality to render the vulnerable parts of his personality invisible, she acknowledges having experienced intense feelings of boredom that appeared reflective of her patient's mechanical way of being in the room with her. She says that,

> …When it's boredom, you look at boredom and think oh there's rage that's not being expressed, but I couldn't get it and my client couldn't talk about it…I felt that we were just going through the motions…(R4, NMU 757 – 759, p. 154).

Close analysis of the above extracts shows that in the absence of explicit transference, the countertransference emerges as a royal road to the patient's implicit transference material and functions as an access route to the split off and projected parts of the patient's personality that otherwise seem unconscious and inaccessible.

As such, strong countertransference in the absence of explicit transference manifestations emerges as a key diagnostic indicator of the patient's underlying developmental status as pre-oedipal and a signal for the kind of work required in developing and strengthening the integrity of the patient's ego and capacity for becoming conscious of otherwise split off and projected parts of the personality.

In this regard, it is interesting to note that unlike explicit transference manifestations that function as a resistance to the therapeutic process, implicit transference material, manifest in the therapists' countertransference in the form of an unconscious communication, appears to function in the service of defending the patient's ego against experiencing intolerable feelings and emotional states.

For this reason and as close analysis of the interviews shows, in the absence of explicit transference there appears to be a shift in emphasis from the centrality of interpreting or working in the transference to remove it as a resistance to the therapeutic process to the centrality of countertransference analysis in receiving and understanding the patient's unconscious communication (implicit transference) and in formulating the kinds of

interpretations that articulate and make explicit the split off and projected emotional material in a way that that patient can recognize and integrate as his/her own.

In other words, in the absence of explicit transference, there is a shift in emphasis from making the unconscious conscious by interpreting or working in the transference to an emphasis on developing within the patient a greater capacity for becoming conscious of the unconscious by using the countertransference as a key source of clinical data and technical tool in doing so.

In this regard, R1 for example demonstrates how she uses her countertransference experience in relation to her 'very anxious' patient to begin talking about what she thought was going on inside him. She says for example that,

> …It was kind of putting it into words for him which made sense for him which over time gradually allowed him to pick up on some of the things and start talking a bit about…I spoke much more about what I thought was going on inside of him, then gradually he started to relate it to what is happening in his work pretty much and also his history…(R1, NMU 336 –342, p. 84).

R2 emphasises countertransference analysis in receiving, understanding and processing her patient's implicit transference material objectively before using it interpretively to make conscious her patient's unconscious communication. She says that,

> …Your first duty is that you survive and the patient survives…so you've got to then first be busy with yourself…I've got to be busy with myself as the therapist to first survive before I bring, can give anything back if I can…(R2, NMU 645 – 661, p. 109).

For R2, countertransference analysis appears to play an important role in containing, digesting and "de-poisoning" the patient's implicit transference material before using it in formulating interpretations that give back in words the patient's projected emotional material. She says in this regard that,

> …My not talking about how he makes me feel was very important…my taking it in, my talking everything from him and being able for some reason to tolerate the enormous anxiety…and kind of digest it again and again…I stayed with this anxiety for many months until it became less…it was still years before I could actually give it back to him…(R2, NMU 204 –223, p. 99).

R2 explains the importance of maintaining technical neutrality when using her countertransference in formulating interpretations that articulate her patient's unconscious communications in a way that he can understand, recognize and integrate as his own. She says for example that,

> …If I'm terrified of him hurting me surely I'm not in a state to give any meaningful answer back until it is properly digested, I can give it back as something devoid of anything attacking, truthfully to give it back to him so that he can think about it and understand it…(R2, NMU 355 - 358, p. 102).

Like R1, therapist R3 highlights the role of her countertransference in accessing and understanding implicit transference material as an unconscious communication and in formulating the kind of interpretation that attempts to put the patient in touch with their emotions or at least alert them the 'missing' affect. She says for example that,

> …If the person is not in touch with their own feelings…sometimes the feelings in me and I can feel it and then I know it's there…you'll pick up all the pain for this yet they're talking in a very detached way, then I might suggest that what they're saying is very painful but they never seem to bring any feeling into and I wonder about that…(R3, NMU 153 – 166, p.119)

Like R2, R3 also emphasises the role of her countertransference in containing her patient's implicit transference material before interpreting it. She says for example that,

> …I don't feel that saying that will get her there…I feel I have to wait…I actually have it in me and wait…(R3, NMU 156 – 158, p. 119)

R4 emphasizes countertransference analysis in identifying and accessing material that pertains to and constitutes her "invisible" patient's unconscious communications. She says for example that,

> …It sometimes is about what alerts me to stuff that I need to go work on in myself but often I try and understand it…if it doesn't feel like my own issue, then it is about what I think the client is trying to communicate to me, kind of the notion of unconscious communication which can be very powerful…(R4, NMU 481 – 483, p. 148)

Speaking more generally in this regard, R4 also describes using her countertransference experience with her clients in formulating interpretations that attempt to return or give back in words their unarticulated emotional experiences or as she puts it, "unconscious communications". In this regard, R4 says that,

> …Often give it back to the patient…I don't just try and do it out of the blue to say well I'm sense that there's a lot of anger in the room and I think it's coming from you…either I look for a hook and say I wonder if that would have evoked the feeling I'm feeling and try and link it to their narrative…(R4, NMU 495 - 498, p. 148).

It is interesting to note from close analysis of the above extracts, how in using the countertransference as a royal road to the patient's implicit transference, the therapists not only position themselves to contain, digest and process the patient's split off and projected emotional material, but in doing so also maintain technical neutrality by keeping their countertransference in check precisely by using it in accessing otherwise inaccessible parts of the patient's personality and in formulating the kinds of interpretations that articulate and make explicit the patient's unconscious communications in a way that the patient can recognize and integrate as his/her own.

By using the countertransference in this way the therapists not only demonstrate the centrality of the countertransference over interpreting or working in the transference in doing the kind of unconscious work that cannot be assumed in the early history of the patient's infant-mother relationship but also in providing the patient with a corrective emotional experience with an object capable of understanding empathically the patient's implicit transference material as an unconscious communication and in interpreting it

without evoking the same kind of defensive splitting and projecting mechanisms that rendered parts of the patient's personality unconscious and inaccessible in the first place.

In so far as the countertransference plays a key role in containing the patient's implicit transference material and in maintaining technical neutrality in the process of doing so, the countertransference emerges as a key means by which the therapist in this study establish the therapeutic setting as a safe environment and foster positive therapeutic relations of the kind conducive for developing within the patient an enhanced capacity for integrated ego functioning and whole object relating.

It is therefore among the kinds of patient's whose psychopathology seems manifest in an absence of explicit transference that the countertransference takes centre stage both in accessing the inaccessible parts of the patient's personality and as a key technical tool in developing within these kinds of patients the capacity to become conscious of the unconscious and in so doing to recognize and integrate otherwise split off and projected parts of their personalities.

In the absence of explicit transference therefore, it is the centrality of countertransference analysis and interpretation that plays a key role in doing the kind of work that can be called developmental and that for R1, R2 and R3 also "prepares the ground" for, the transference to manifest more explicitly in the room and, interpreting or working in the transference in the classical sense of making the unconscious conscious by tracing or attributing the patient's relation to the therapist to an/other earlier figure in the past.

4.5 Extended Description of Central Themes

Analyses and categorization of the central themes both prompted by the interview guide and as they emerged spontaneously across the participating therapists was formulated into an extended description of how the therapists practice psychoanalytic psychotherapy generally and in the absence of explicit transference. The extended description is presented below and constitutes the findings of this study.

A range of diverse psychoanalytic theories and theorists inform the practice of psychoanalytic psychotherapy. The role of theory plays a central role in understanding and assessing the patient's developmental status rather than informing a predetermined set of therapeutic techniques.

Diagnosis and assessment of the status of the integrity of the patient's ego and nature of the patient's capacity for object relating are central guiding principles in determining the aims of treatment and the principles guiding the application of certain therapeutic techniques in approximating achievement of these aims.

A range of in-the-room assessment indices include a focus on the content of the patient's presenting material; the nature of the patient's anxieties, the patient's degree of self-understanding and awareness; and the patient's patterns of relating with significant others. The nature of the patient's capacity for object relating and self-other experiences evinced in the transference-countertransference relationship is another important in-the-room diagnostic indicator of the status of the patient's developmental functioning where the degree of distortion in the patient's relation/attachment to the therapist can be considered diagnostic of the degree of psychological disturbance present. As a general rule the more distorted the transference, the more psychologically disturbed the patient can be considered to be.

The relationship between theory and practice in psychoanalytic psychotherapy tends to be based on the importance of diagnosis and assessment of the patient's level of functioning expressed in developmental terms as 'pre-oedipal' or 'oedipal' rather than on the blind application of a set of predetermined techniques or the strict adherence to any one particular psychoanalytic theorist, theory or orientation.

While the centrality of interpreting or working in the transference is recognized and acknowledged as a key therapeutic tool in making the unconscious conscious in psychoanalytic oriented psychotherapy, it is not always considered appropriate to do so with every patient and in every therapeutic situation.

Among more psychologically disturbed patients, it is generally considered important to work at the level of the patient's ego, which often precludes the importance of immediately making the unconscious conscious by interpreting or working in the transference. Also, there are other techniques available to the psychoanalytic psychotherapist for effecting what can still be called unconscious work without specifically interpreting or working in the transference.

In psychoanalytic psychotherapy, the centrality of interpreting or working in the transference emerges as a function of a number of interacting criteria the most important of which include: 1) the patient's developmental functioning and the integrity of the patient's ego, 2) the frequency of weekly therapy sessions, 3) the affective nature of the patient's relation/attachment to the therapist, 4) how the transference material is treated and interpreted by the therapist and related to this, the 5) clarity of the countertransference.

The centrality of interpreting or working in the transference to make the unconscious conscious emerges as a function of the patient's developmental status where as a general rule the more developed the patient, the more indicated it is to interpret or work in the transference **unless** the transference manifests explicitly in the room as a resistance to the therapeutic process in which case **irrespective** of the patient's developmental status it is indicated to interpret or work in the transference to remove it as a source of resistance to the therapeutic process. In this regard, the importance of formulating interpretations that the patient can understand and make sense of is emphasised.

Since the transference tends to manifest more explicitly as a resistance to the therapeutic process as a function of the frequency of weekly sessions, it is generally indicated to interpret or work in the transference resistance in more frequent weekly sessions.

The affective nature of how the transference manifests explicitly as a resistance to the therapeutic process also emerges as a function of the patient's developmental status where as a general rule among more psychologically developed patients the transference

tends to manifest explicitly as a resistance to the therapeutic process more commonly in the form of the positive erotic transference. (This does not mean that the transference cannot manifest explicitly as a resistance in the form of the negative transference among more psychologically developed patients. This theme did not, however, emerge in the interviews).

In contrast, among more psychologically disturbed patients, the transference tends to manifest explicitly as a resistance to the therapeutic process more commonly in the form of the negative transference.

While the positive erotic transference resistance among more psychologically developed patients tends to be an expression of the wish for satisfaction of infantile sexual id impulses, the negative transference resistance among more psychologically disturbed patients tends to be a protest against feeling 'unsafe' as a result of the frustration of unmet dependency needs.

The centrality of removing the negative transference resistance among more psychologically disturbed patients emerges as a function of **how** the negative transference resistance is treated and interpreted.

Among more psychologically disturbed patients it is indicated to remove the negative transference as a resistance to the therapeutic process by **treating** it objectively as non-transference and in **accounting** for it in terms of the patient's relation to the therapist as a real figure in the so-called here-and-now **before** treating and interpreting it as transference – that is, before tracing or attributing the patient's relation to the therapist to an/other figure from the past in the so-called there-and then.

The centrality of interpreting or working in the negative transference resistance among more psychologically disturbed patients emerges as a function of the extent to which the therapist **understands** the patient's negative transference material as non-transference

first and in formulating the kinds of interpretations of it that **mirror** the patient's feelings and **reflect** the therapist's empathic understanding of it in the here-and-now.

In so far as the negative transference among more psychologically disturbed patients tends to manifest as a resistance to the therapeutic process in the form of a protest against feeling unsafe in response to the frustration of implicit ego, or unmet dependency needs, removing the negative transference resistance to restore the therapeutic process among more psychologically disturbed patients emerges by implication as a function of meeting the patient's ego needs empathically – that is, with interpretations that mirror the patient's feelings and reflect the therapist's empathic understanding of them as a protest against feeling 'unsafe' in relation to the therapist as a real figure in the here-and-now.

When working in the negative transference resistance among more psychologically disturbed patients, the therapist's countertransference emerges both as a hindrance and as a potential key tool. The countertransference can, however, be kept in check paradoxically by using it in understanding and interpreting the patient's negative transference resistance as non-transference. Technical neutrality can therefore be maintained paradoxically by meeting the patient's implicit ego needs with interpretations that reflect the patient's feelings and the therapist's empathic understanding of them as a protest against feeling unsafe.

The centrality of keeping the countertransference in check by using it as a key tool in understanding and treating the patient's transference as non-transference and maintaining technical neutrality paradoxically by meeting the patient's unconscious ego needs interpretively emerges as a function of the **clarity** of the countertransference.

As a general rule the clearer the countertransference, the more readily it can be kept in check by using it in understanding and in interpreting or working in the negative transference resistance as non-transference.

In situations where the countertransference is unclear and cannot be kept in check by using it in meeting the patient's implicit ego needs interpretively, technical neutrality can be maintained by meeting the patient's ego needs paradoxically by accounting for failing to do so empathically/interpretively.

Countertransference analysis plays an important role in positioning the psychoanalytic psychotherapist to maintain technical neutrality when interpreting or working in the negative transference resistance as non-transference among more psychologically disturbed patients and functions not only as a key tool in understanding and interpreting the patient's negative transference material objectively as non-transference, but in guiding the therapist as to **when** it is most appropriate to do so.

In psychoanalytic psychotherapy the maintenance of technical neutrality emerges as a central guiding principle and countertransference analysis as a key tool in determining whether or not it is indicated to interpret or work in the transference among more psychologically disturbed patients – the kinds of patients with whom it is not as a general rule considered appropriate to do so.

There are situations and conditions peculiar to both the setting and the kinds of patients who present for treatment in psychoanalytic psychotherapy that call into question the centrality of interpreting or working in the transference both in the classical sense of making the unconscious conscious by treating and interpreting the patient's affective relation to the therapist as transference proper – that is by attributing or tracing the patient's relation to the therapist to an/other object in the past, **or** in a more contemporary sense, by first treating and interpreting it objectively as non-transference – that is, allowing it to pass as real by accounting for it in terms of the patient's relation to the therapist as a real figure in the here-and-now.

In so far as the centrality of interpreting or working in the transference emerges as a function of the extent to which the transference manifests explicitly as a resistance to the

therapeutic process, in the absence of explicit transference, it is as a general rule not indicated to interpret or work in the transference.

An absence of explicit transference manifestations in the room, however, does not automatically mean that there is no transference material present. When the transference does not manifest explicitly in the room as a resistance to the therapeutic process the transference can, via splitting and projective mechanisms, manifest implicitly in the therapist's countertransference experience as an unconscious communication of split off and projected emotional material.

Strong countertransference in the absence of explicit transference manifestations signals the presence of split off and projected emotional material and emerges therefore as a royal road to the patient's implicit transference and a key diagnostic indicator of the patient's underlying developmental status as pre-oedipal.

In the absence of explicit transference manifestations, strong countertransference incongruous with the therapist's usual therapeutic stance and reflective of the patient's implicit transference (split off and projected emotional material) signals the presence of the kind of psychopathology or psychological disturbance that requires something different from the therapist than interpreting or working in the transference.

Among the kinds of patient's who present in psychoanalytic psychotherapy as seemingly functional in their work but in their capacities for object relating evince the kind of deficits in establishing close and emotionally meaningful contact, an absence of explicit transference emerges as a manifestation in the room of the 'symptom' that comes for treating rather than as a function of the frequency of weekly sessions alone.

It is among the kinds of patients in other words who present with pathology manifest in an absence of explicit transference and who seemingly function outside the therapeutic reach of the patient-therapist relationship as a result, that the countertransference emerges as a key access route to otherwise inaccessible areas of their personalities.

As a royal road to the patient's implicit transference, the countertransference plays a key role in accessing the split off and projected parts of the patient's personality. In the absence of explicit transference manifestations therefore, the countertransference is not only a key diagnostic indicator of pre-oedipal developmental psychopathology but also a key therapeutic tool in receiving and understanding implicit transference material as an unconscious communication.

By contrast to explicit transference material that functions in the service of resistance to the therapeutic process, implicit transference material, manifest in the therapist's countertransference as an unconscious communication, functions in the defensive service of the patient's seemingly fragile ego against experiencing intolerable feelings and/or emotional states.

In the absence of explicit transference manifestations, a technical difference emerges between the kind of work involved in bringing implicit transference material into consciousness and the kind of work involved in removing explicit transference material as a resistance to the therapeutic process.

This technical difference is reflected in a shift in emphasis from interpreting or working in the transference to remove it as a source of resistance to the therapeutic process to an emphasis on establishing the setting as a safe environment and in fostering positive therapeutic relations conducive to the development of the patient's capacity to become conscious of the unconscious and in 'preparing the ground' for the centrality of interpreting or working in the transference.

In emphasising establishing the setting as a safe environment and positive therapeutic relations over immediately interpreting or working in the transference, three techniques stand out as key. These include working with the material the patient brings into the room objectively as non-transference, containing split off and projected emotional material (implicit transference) and maintaining technical neutrality by assuming the role of an empathic, understanding and non-judgmental figure.

In working with the material that the patient brings objectively (i.e., by not treating it as transference), there is an emphasis placed on exploring the patient's history, the nature of his/her anxieties and relations outside the room. Linking past and present without linking it to the patient's relation to the therapist specifically – that is without making the transference link in the room, naming, labelling and giving words to the patient's unarticulated feelings play an important role in establishing the setting as a safe environment.

Process comments are emphasised in bringing to the patient's attention that there are aspects of their personalities and emotional experiences with which they are out of touch. Process comments play a central role in 'preparing the ground' for the emergence of more explicit transference material and for interpreting or working in the transference in psychoanalytic psychotherapy.

Containing projected emotional material - that is, understanding, digesting and processing implicit transference material plays an important role over directly interpreting or working in it as transference. Containing plays an important role in formulating interpretations that give back in words split off and projected emotional material and that make explicit implicit transference material in a way that brings to consciousness the patient's unconscious communications. The centrality of containing over immediately interpreting or working in the patient's implicit transference material is emphasised in establishing the setting as a safe environment conducive for developing integrated ego functioning and a capacity to become conscious of the unconscious.

In the absence of explicit transference manifestations, the psychoanalytic psychotherapist is able to position him/herself to maintain technical neutrality by assuming the role of an understanding empathic non-judgmental figure. Among the kinds of patients whose pathology seems manifest in an absence of explicit transference, technical neutrality is maintained precisely by not interpreting or working in the implicit transference – that is neither in accounting for it in terms of the patient's relation to the therapist as a real

figure in the here and now, nor in tracing or attributing it to a figure in the past in the there-and-then.

It is among the kinds of patients with whom the transference tends to manifest implicitly in the countertransference as an unconscious communication rather than explicitly as a resistance to the therapeutic process that there is a shift in emphasis from transference analysis and interpretation to countertransference analysis and interpretation.

As a royal road to the patient's implicit transference and key access route to inaccessible areas of the patient's personality, countertransference analysis and interpretation plays a central role in **establishing** the setting as a safe environment conducive to developing within the patient a capacity for becoming conscious of the unconscious over interpreting or working in the transference to **restore** the setting as a safe environment.

While the countertransference plays a central role in working in the transference resistance, there is, however, a difference between using the countertransference in formulating interpretations that remove explicit transference material to restore the therapeutic process and using the countertransference in formulating interpretations that give back in words the patient's implicit transference to establish the setting as a safe environment in the first place.

Instead of using the countertransference in understanding the patient's explicit transference resistance as a protest against feeling unsafe and in formulating interpretations that remove it by accounting for it in terms of the patient's relation to the therapist as a real figure in the here-and-now, in the absence of explicit transference, the countertransference is used in understanding the patient's implicit transference as an unconscious communication and in formulating interpretations that make explicit implicit transference material **without** any reference to the therapist at all.

In the absence of explicit transference manifestations, the countertransference plays a central role in working **WITH** implicit transference material by interpreting the

countertransference rather than by interpreting or working directly in the implicit transference.

In treating psychoanalytically the kind of pathology that seems manifest in an absence of explicit transference, technical neutrality is maintained by working **with** rather than **in** the implicit transference. The countertransference plays a central role in maintaining technical neutrality in this way.

In the absence of explicit transference, technical neutrality is maintained in the process of establishing the setting as a safe environment by keeping the countertransference in check precisely by using it in working with the material the patient brings into the room as non-transference, containing digesting and 'de-poisoning' split off and projected emotional material, in formulating interpretations that make explicit implicit transference material and in positioning the therapist to function as an empathic benign figure in doing so.

CHAPTER 5

DISCUSSION OF FINDINGS

Despite the centrality of transference analysis and interpretation across the current plurality of psychoanalytic approaches (Bird, 1972; Schwaber, 1990; Cooper, 1992; Kernberg, 1993, 1999; Riesenberg-Malcolm, 1995; Galatriotou, 2000), the findings of this study show that there are situations and conditions peculiar to the setting in which psychoanalytic psychotherapy is practiced and patients who present for treatment with the kind of pathology and developmental status that call into question the centrality of transference analysis and interpretation as a key agent in effecting intrapsychic change.

For example, like the kinds of patients described in the international literature on seeming 'absent' transference or transference that feels 'blank' (McDougall, 1978; S. Klein, 1980; Quinodoz, 1996; Eshel, 1998; Emanuel, 2001), there are patients who present for treatment in psychoanalytic psychotherapy with the kind of pathology that not only lends justification to a question on 'absent' transference in a local contemporary psychoanalytic setting, but support for conceiving of the idea of pathology manifest in an absence of explicit transference that requires something different than directly interpreting or working in the transference in the classical sense to effect what can be called in-depth or unconscious work.

In this regard it is interesting to note that while an absence of explicit transference in psychoanalytic psychotherapy can be a function of the frequency of weekly sessions, it is among the particular group of patients described by the therapists in this study that an absence of explicit transference emerges as a function of their underlying psychopathology and developmental status as pre-oedipal.

An absence of explicit transference among these kinds of patients emerges more specifically as a manifestation of the symptom that comes for treating than can be

attributed to once-a-week therapy sessions or remedied by scheduling more frequent weekly sessions alone.

As close analysis of the interviews shows, it is these kinds of patients who, in their failed capacities for object relating (and hence transference), not only raise the question of analysability among more Freudian oriented psychotherapists, but demonstrate functioning both outside of a position that Klein theorized and seemingly beyond the therapeutic reach of the therapist-patient relationship.

It is among the kinds of patients described in this study whose pathology, manifest in an absence of explicit transference and seemingly outside of what is theoretically conceivable from both a classical Freudian and Kleinian perspective, I am suggesting seems best accounted for by Winnicott's (1960a) conceptualisation of a False/True-self split and disturbance originating in the earliest stages of the infant-mother relationship prior to both Freud's (1905) Oedipus complex and Klein's (1946; 1952) paranoid schizoid position.

In theorizing the idea of a true-self which as a result of the defensive function of a false-self remains pathologically isolated and withdrawn from contact with external reality and the objects in it, I am suggesting that it is Winnicott's (1960a) concept of a false/true-self split that not only accounts for the kind of pathology that seems manifest in an absence of explicit transference, but makes what is practically possible to observe in the clinic theoretically possible to conceive of.

It is Winnicott's (1960a) concept of a false/true-self split that I am suggesting seems to provide the best theoretical 'goodness of fit' for the intriguing observation that among the variety of patients presenting for treatment in psychoanalytic psychotherapy there is a particular group or "clinical family" who present with a facade of functioning on the one hand that in terms of their capacities for work seems to place them on the high end of the intellectual continuum while on the other hand in terms of their failed capacities for

object relating, places them practically back in the womb and seemingly outside of the reach of the therapeutic relationship.

Like the patient's described in the international literature who present as seemingly suitable candidates for psychoanalysis but demonstrate over time areas of their personalities that are inaccessible and manifest in a seeming 'absence' of transference or transference that feels 'blank' (McDougall, 1978; S. Klein, 1980; Quinodoz, 1996; Eshel, 1998; Emanuel, 2001), the patients described in this study to varying degrees also demonstrate inaccessible areas of their personalities that I am suggesting, like their international counterparts, seem best accounted for by Winnicott's (1960a) concept of a false/true-self split.

Hard to miss for example in R2's description of her patient as a 'conman' and whose contact with her she describes as "pseudo", are the parallels with Winnicott's false-self presenting with a show of being real. Equally hard to miss is the suffering captured by the sense of futility of Winnicott's false-self in R3's description of her patient's feeling that everything in her life is "meaningless" including her career that does not matter to her.

While R1's description of her patient as a "good boy" who has done well professionally but appears to be "out-of-touch" with himself emotionally echoes Winnicott's false/true-self split, it is R3's description of her patient who only knows how to pretend to be a human that captures most strikingly of all Winnicott's idea of a false-self which in pretending how to be human leaves concealed an undeveloped and 'unformed' true-self pathologically isolated and withdrawn from contact with external reality. The parts of R4's 'very defended' client's personality that he appears to have split off captures Winnicott's idea of a false/true-self split further.

It is among the kinds of patients described by the therapists in this study who present with areas or aspects of their personalities that are inaccessible, difficult to reach, split off and seemingly manifest in an absence of explicit transference that not only echo Winnicott's

(1960a) idea of a true-self pathologically isolated and withdrawn from contact with external reality and the objects in it, but that like Winnicott's (1955) true-self, require something different than interpreting or working in the transference in the classical sense to effect what can still be called unconscious work.

In so far as the findings of this study show that in the absence of explicit transference manifestations, the transference tends to manifest implicitly in the therapists' countertransference as an unconscious communication of split off and projected emotional material, it seems plausible to suggest that the implicit transference among the kinds of patients described by the therapists belongs to, or acts in the service of, the defensive function of the false-self that requires something different than transference interpretation in removing it as a defence against the threat of annihilation of the true-self and in accessing otherwise inaccessible areas of the patient's personality – the true-self in other words.

Even further parallels in support of a conceptualisation of pathology manifest in an absence of explicit transference based on Winnicott's (1960a) false/true-self split emerge in this study in terms of how the participating therapists describe practicing psychoanalytic psychotherapy in the absence of explicit transference manifestations.

In this regard it is interesting to note that while the therapists do not explicitly mention the role of Winnicott's technical advice, they appear to follow and carry it out intuitively when working in the absence of explicit transference. It is therefore a contribution that this study makes in locating the kind of therapeutic action described by the therapists within the context of an existing psychoanalytic theory that not only accounts for the kind of pathology that seems manifest in an absence of explicit transference but that also resolves the paradoxical question of how one might work psychoanalytically in the seeming absence of the tool that defines the work as psychoanalytic – that is without interpreting or working in the transference. It is among the kinds of patient's with who integrated and intact ego functioning cannot be assumed that the findings of this study

suggest support for Winnicott (1955) and Stern et al's (1998, p. 903) idea that 'something more' than transference interpretation is needed in effecting intrapsychic change.

For example, as the findings of this study show, like Winnicott (1955) who emphasises managing the setting over interpretation in shifting the patient's main site of functioning from a false to a true-self, when working in the absence of explicit transference, all the therapists emphasise establishing the setting as a safe environment over directly interpreting or working in the transference in providing the conditions conducive for doing the kind of developmental or foundational work that cannot be assumed to be a fact in the earliest history of the patient's infant-mother relationship.

It is in emphasizing establishing the setting as a safe environment over interpreting or working in the transference that the therapists in this study appear to adhere to Winnicott's (1955) technical advice of meeting the unconscious hope of the false-self in providing the conditions in which the true-self can come into being without impingement – that is without interpreting the transference.

Drawing on Winnicott's (1960a) work in this area and based on how the therapists in this study appear to work in the absence of explicit transference manifestations, it can be suggested that in meeting the unconscious hope of the false-self by establishing the setting as a safe environment, conditions conducive to the false-self feeling safe to hand over or relinquish its task of holding the true-self to the therapist are provided and the process of transforming pathological withdrawal into an organized regression to dependence facilitated (Winnicott, 1954c).

Also, with the therapist 'holding' the true-self rather than the false-self doing so, pathological isolation of the true-self is transformed into an organized regression to dependence marking a return to the "original success situation of primary narcissism" from which state true ego development can proceed undisturbed and without necessitating the use of the defences that result in the pathological isolation and

withdrawal of parts of the patient's personality in the first place (Winnicott, 1954c, p. 286).

In other words, in emphasizing establishing the setting as a safe environment, not only is the compliance of the false-self transformed into co-operation by putting its defensive function out of commission without interpreting or working in the transference that seemingly belongs to it, but access is gained to otherwise pathologically isolated and withdrawn parts of the patient's personality. The opportunity is provided for starting afresh with good enough albeit belated adaptation (Winnicott, 1954c).

In this regard it is interesting to note how in the absence of explicit transference manifestations, countertransference analysis and interpretation takes centre stage in establishing the setting as a safe environment and in positioning the therapist to assume the kind of role that once again parallels or echoes Winnicott's (1956) concept of a "good-enough mother" and also the shift noted in the contemporary psychoanalytic literature from conceiving of the psychoanalytic project as a one-person to a two-person psychology (Wasserman, 1999).

As the findings of this study show, in the absence of explicit transference material in the room the countertransference emerges as a royal road to the patient's implicit transference and key access route to areas or aspects of the patient's personality that are otherwise inaccessible and seeming outside of the reach of the therapeutic relationship.

It is by using the countertransference, like their international counterparts (McDougall, 1978; Joseph, 1975; S. Klein, 1980; Bollas, 1987; Gomberoff et al, 1990; Mitrani, 1992; Quinodoz, 1996; Ogden, 1995; Eshel, 1998; Emanuel, 2001), to receive and understand the patient's implicit transference material as an unconscious communication of split off and projected emotional material, that the therapists in this study position themselves to meet the patient's ego needs or unmet dependency needs empathically and in a way that echoes Winnicott's (1956) idea of the good enough mother who as a result of her heightened state of identification – her primary maternal preoccupation, is able to

understand and meet her infant's needs reliably– that is, without language and not in any mechanistic sense.

Also, in so far as the therapists in this study use the countertransference in formulating interpretations that make explicit implicit transference material in a way that returns split off and projected emotional material, like the good-enough mother who brings the world to her infant in manageable increments and meets her infant's omnipotence, the therapists in this study demonstrate how they make conscious the patient's unconscious communications in a way that the patient can recognize, accept and integrate as his/her own and that parallels Bion's concept of containment.

In this regard a difference emerges between interpreting or working **in** the transference in the classical sense of making the unconscious conscious with interpretations that trace back, or attribute the patient's relation to the figure of the therapist to an/other significant figure in the past and what I am calling working **with** implicit transference material by using the countertransference in formulating interpretations that give back in words the patient's split off and projected emotional material or that make explicit implicit transference manifestations. (It is important to note here that working **with** implicit transference does not involve direct countertransference disclosures).

The therapist in other words meets the patient's omnipotence allowing for the illusion of primary creativity by bringing the unconscious into consciousness by working **with** implicit transference material in a way that renders otherwise intolerable feelings tolerable and facilitates the development of integrated and intact ego functioning without directly interpreting or working **in** the transference. That is, without evoking the use of the very defences that result in splitting and projective mechanisms in the first place.

In this regard parallels with Bion's (1962) concept of 'containing' and the role of the therapist as a 'container' for the patient's unprocessed unconscious material also emerge in this study and illustrate the important technical role that 'containing' plays in working **with** implicit transference – in both 'holding' the patient and in establishing the setting as

a safe environment among the kind's of patients who present with pathology manifest in an absence of explicit transference.

On the basis of the findings of this study, it seems plausible to suggest that Bion's (1957, 1962) work and theorizing belongs to the same order of work that Winnicott (1955) describes when working among the kinds of patients with whom good enough adaptation in the earliest stages of development cannot be assumed.

While the parallels in this study with Winnicott's (1955; 1960a) work and conceptualisation of pathology in terms of a false/true-self split are striking, the divergences from classical technique and convergences with more contemporary practice seem equally striking and important.

In this regard, it is interesting to note how psychopathology manifest in an absence of explicit transference and best accounted for in terms of Winnicott's false/true-self split not only provide a context for understanding the shifts from classical to contemporary practice in terms of the changed role of the countertransference from obstacle to key tool but suggest support for Wallerstein's (1990) emerging technical common ground across historically competing psychoanalytic orientations.

In so far as all the therapists drawing on diverse theoretical orientations and influences emphasise the centrality of countertransference analysis and interpretation in establishing the setting as a safe environment conducive for doing the kind of work that according to Winnicott (1955) cannot be assumed done in the early history of the kinds of patients whose psychopathology seems manifest in an absence of explicit transference, Wallerstein's (1990) technical common ground emerges in this study on Winnicottian terrain.

As the findings of this study show, psychoanalytic oriented practice is no longer limited to making the unconscious conscious and no longer exclusively dependent on directly interpreting or working in the transference to do so.

Based on close reading of how the therapists work in the absence of explicit transference, the findings of this study not only support Pines (1992) distinction between conflict and developmental work but reflect a shift in focus from transference analysis and interpretation to countertransference analysis and interpretation in doing the kind of work that echoes Winnicott's (1955) advice in shifting the main site of functioning from a false to a true-self.

It is on the basis of doing the kind of developmental work described by the therapists in this study that echoes Winnicott's (1955) advice and reflects divergences from classical technique and convergences with more contemporary practice, that the transference emerges no longer exclusively as a technical tool but a key diagnostic one, and that the countertransference claims its changed place as an obstacle to both a key diagnostic and technical tool in developing within the patient a capacity for becoming conscious of the unconscious. For doing the kind of work in other words that can be called developmental.

As close analysis of the interviews shows, in contrast to Freud (1913) for example who recommended a trial period for assessing a patient's suitability for psychoanalytic treatment with particular emphasis placed on the patient's capacity for transference, the therapists in this study emphasise the importance of assessing and diagnosing the patient's developmental status in determining both the aims and means of treatment.

Rather than base the question of analysability exclusively on the patient's capacity for transference therefore, the findings of this study show that the therapists focus on understanding the patient's developmental status and use both the transference and the countertransference to this end.

It is in psychoanalytic psychotherapy as it is practiced among the participating therapists, that there is a shift reflected from a classical focus on transference in determining the patient's suitability for the process to a more contemporary focus on both the transference

and countertransference interchange as diagnostic indicators and signals for the kind of work that differs from classical psychoanalysis as originally described by Freud.

From among the number of what might be called in-the-room assessment indices of the patient's developmental status and ego functioning that emerge in this study, including the patient's history, the nature of the patient's anxieties, degree of self understanding and relations with others outside the room, it is the patient's transference and the therapist's countertransference that stand out as key.

For example, the participating therapists indicate a focus on the affective nature of the patient's relation to the therapist (either positive or negative) and how the transference manifests or fails to manifest explicitly in the room as a resistance to the therapeutic process as diagnostic of the patient's developmental status and in determining the centrality of interpreting or working in the transference.

As close analysis of the interviews shows, it is interesting to note that both explicit negative transference material, manifest in the form of a protest against feeling unsafe **and** a seeming absence of explicit transference manifestations together with strong countertransference feelings among the kinds of patients who demonstrate failed capacities for object relating both in the room and out, emerge as diagnostic of the patient's developmental status as pre-oedipal and signal the presence of psychological disturbance that can be traced back to the earliest stages of the infant-mother relationship prior to Freud's Oedipus.

It is important to note, however, that an absence of explicit transference manifestations cannot alone be considered diagnostic of underlying developmental pathology. As close analysis of the interviews shows, an absence of explicit transference manifestations can also be a signal that the therapeutic process is well underway and requires nothing other than the consistent, reliable and attentive presence of the therapist – as a background object (Eshel, 1998).

It is therefore the kind of psychopathology that manifests explicitly in the room as a resistance to the therapeutic process in the form of the negative transference, **or** that fails to manifest explicitly in the room as a resistance to the therapeutic process but rather implicitly in the therapist's countertransference in the form of an unconscious communication of split off and projected emotional material, that signals the kind of work that differs technically from Freud's classical psychoanalysis and echoes Winnicott's (1955) advice when working among the kinds of patients with whom integrated and intact ego functioning cannot be assumed.

Based on close reading of the kind of work that the therapists in this study do both in the absence of explicit transference manifestations and in the presence of explicit negative transference, there is a shift reflected from a focus on the centrality of transference analysis and interpretation in the classical sense of making the unconscious conscious to the centrality of countertransference analysis in both establishing and restoring the setting as a safe environment in which to develop within the patient a capacity for becoming conscious of the unconscious. For developing integrated and strengthening ego functioning in other words.

In this regard it is interesting to note that both explicit negative transference manifestations as well as an absence of explicit transference manifestations emerge in this study as belonging to the same order of pathology that in contrast to Freud's psychoneuroses or transference neuroses can be traced to the earliest infant-mother relationship prior to Oedipus.

It is therefore the kind of psychopathology manifest in either explicit negative transference or in an absence of explicit transference together with strong countertransference that signals a shift from the classical role of the countertransference as an obstacle to the more contemporary idea of the countertransference as a key tool and a change in the therapeutic role from 'blank screen' to 'good-enough' mother.

While explicit negative transference material and an absence of explicit transference manifestations appear to belong to the same order of pathology, there is, however, a technical difference involved between removing explicit negative transference material as a resistance to the therapeutic process in a way that **restores** the setting as a safe environment **and** rendering implicit transference material explicit in a way that **establishes** the setting as a safe environment in the first place.

As close analysis of the interviews shows, this difference appears to be reflected in how the countertransference is used in formulating the kinds of interpretations of explicit negative transference material that remove it as a source of resistance to restore the patient's experience of the setting as a safe environment and in formulating the kinds of interpretations that make explicit implicit transference manifestations – that give back in words split off and projected emotional material in a way that brings the patient's unconscious communication into consciousness and establishes the setting as a safe environment in the process of doing so.

The difference that emerges in this study between establishing and restoring the setting as a safe environment appears to be reflected in the difference between using the countertransference in the absence of explicit transference in working **with** implicit transference material (i.e., containing) rather than directly **in** it and using the countertransference in interpreting or working in explicit negative transference material objectively as non-transference **before** treating and interpreting it as transference proper.

In other words, instead of remove explicit negative transference material as a resistance to the therapeutic process in the classical sense of making the unconscious conscious by tracing or attributing the patient's relation to the therapist to an/other figure in the past, the emphasis in this study is placed on removing explicit negative transference material by treating it objectively first and in formulating interpretations that account for it in terms of the patient's relation the therapist as a real figure in the so-called here-and-now before making any genetic (transference) links.

While a key finding of this study emerges in terms of **how** transference material is treated and interpreted by the therapist, a major contribution involves making explicit the implicit conceptual distinction between interpreting or working in the transference as transference - that is, tracing or attributing the patient's relation to the therapist to an/other figure in the past and interpreting or working in the transference as non-transference – that is, accounting for the patient's relation to the therapist as a real figure in the so-called here-and-now.

The conceptual difference between working **in** the transference and working **with** the transference emerges as playing a central role in understanding how psychoanalytic work can still be effected in the absence of explicit transference manifestations without directly interpreting or working in the transference either as transference or as non-transference – that is, without making any reference to the therapist at all - neither as a real figure in the here-and-now nor as a figure from the past in the so called there-and-then.

Contrary to more contemporary debates therefore around whether material in the room is objectively speaking transference or not (Greenson & Wexler 1969), the findings of this study suggest a shift in emphasis from the centrality of interpreting or working in the transference to an emphasis on **how** transference material is to be treated and interpreted as a function of the patient's developmental status. The central question is therefore not whether the transference is interpreted or worked in, but how it is treated and interpreted by the therapist - as transference or as non-transference.

In this regard, while it is striking to note how the therapists in this study intuitively adhere to Freud's (1913) classical advice to leave this most delicate of procedures alone until the transference manifests explicitly in the room as a resistance to the process, it is equally striking to note how in keeping with Winnicott's (1955) advice to treat as objective the psychologically 'unformed' patient's anger and not regard it as negative transference, the therapists in this study intuitively appear or attempt to interpret or work in explicit negative transference as non-transference.

By treating explicit negative transference material objectively and interpreting it as non-transference the therapists in this study formulate what I am calling a developmentally appropriate interpretation of the transference.

A definition of a developmentally appropriate interpretation of the transference that emerges in this study is an interpretation or way of working in the transference that matches the status of the integrity of the patient's ego and in particular, capacity for discerning subject-object differentiation, fantasy from fact and most importantly, transference from reality. In other words a developmentally appropriate interpretation of the transference is an interpretation that is sensitive to the patient's capacity for recognizing, accepting and tolerating difference.

It is on the basis of the idea of formulating developmentally appropriate interpretations of the transference, that the centrality of interpreting or working in the transference among the kinds of patient's with whom integrated ego functioning cannot be assumed emerges in this study as a function of understanding and interpreting transference material objectively as non-transference first rather than on the blind adherence to any one particular theory or orientation.

As the findings of this study show, how transference material is treated emerges as a function of the patient's developmental status and an in-the room assessment of the patient's capacity for discerning subject-object differentiation, fantasy from fact, transference from reality.

Further justification for proposing the idea of formulating what I have called a developmentally appropriate interpretation or way of working in the transference derives from the international literature which articulates different kinds and different levels of interpreting or working in the transference (Minerbo, 2001; Roth, 2001). For example while Gill (1992) mentions the difference between formulating genetic versus here-and-now interpretations, Joseph (1975) has drawn the distinction between process versus content-based interpretations.

Furthermore, in the same way that there are different kinds of transferences (Ehrenreich, 1989) and different kinds or varieties of psychoanalysis (Wallerstein, 1990) there are different kinds of transference interpretations or different ways of interpreting or working in the transference.

The contribution that this study makes is to add to this body of literature the idea of what I am calling a developmentally appropriate interpretation of transference material or way of working in the transference that based on Winnicott's (19550 advice to clinicians and depending on the patient's level of functioning determines whether transference material manifesting explicitly in the room is to be treated objectively and accounted for by the therapist on the basis of being regarded as real or whether it is to be treated as transference and interpreted accordingly.

While the idea of whether the therapist treats transference material that manifests explicitly in the room objectively as non-transference or as transference proper is very interesting if not somewhat novel and controversial, it is equally interesting to note how it seems to recall the work of Winnicott's (1960b) good-enough mother who in meeting her infant's needs allows for the illusion of primary creativity and omnipotence and the opportunity for beginning to exist undisturbed by environmental impingement.

As Winnicott (1951) explains, by meeting her infant's needs the 'good-enough' mother allows her infant the illusion that what it conjures up or creates is real and actually exists. She allows to remain as unresolved in other words the paradox that while "what is good and bad in the infant's life is not in fact a projection, but that everything shall seem to him to be a projection" (Winnicott, 1960b, p. 38)

By treating explicit negative transference material objectively, allowing it to pass as real and not transference in other words, the findings of this study suggest that the therapist like Winnicott's good enough mother not only allows the paradox to remain as unresolved that while what is actually transference but from the patient's perspective seems real, shall be allowed to seem as real, but in so doing facilitates the development of

a confident sense of self or 'me-ness' and a secure basis from which to begin experiencing and discerning the distinction between 'me' and 'not-me' and tolerating the frustration of relinquishing infantile omnipotence. As Winnicott (1960b, p. 38) writes,

> Here we find omnipotence and the pleasure principle in operation, as they are certainly are in early infancy; and to this observation we can add that the recognition of a true 'not-me' is a matter of the intellect; it belongs to extreme sophistication and to the maturity of the individual.

It is therefore by treating the more psychologically disturbed (pre-oedipal) patient's explicit negative transference objectively that the psychoanalytically oriented therapist not only formulates a so-called developmentally appropriate interpretation of it that matches the status of the integrity of the patient's ego, but in doing so effects the kind of work that cannot be assumed done in the early history of the patient's infant-mother relationship.

As the findings of this study show it is in treating explicit negative transference material objectively and in formulating what I have called developmentally appropriate interpretations of the transference or ways of working in the transference that the countertransference stakes its claim as a central analytic tool.

In situations where the transference manifests explicitly as a resistance to the therapeutic process in the form of the negative transference (as a protest against feeling unsafe), it is interesting to note how the countertransference emerges both as a potential hindrance and a key tool.

However, as close analysis shows, by using the countertransference constructively to identify or empathise with, and understand what the patient is feeling, the therapist is positioned in a way that, like Winnicott's good-enough mother, allows to remain as unresolved the paradox that while what is objectively speaking transference and not real but which from the patient's perspective seems real, shall be allowed to seem as real – at least for the time being.

By using the countertransference in understanding the patient's material objectively, that is by allowing it to pass as real, the therapist like Winnicott's good enough mother who gives her infant the illusion that what it creates is real and actually there, allows the patient the initial illusion that what the patient thinks is real, is actually real (at least initially)

The therapist in other words allows the patient the illusion of sameness and reflects this in an interpretation that articulates in words what the patient feels. In doing so, the therapist meets the unconscious need for symbiosis symbolically by working in the transference as non-transference with interpretations that bring news of sameness.

By matching the patient's ego in this way, the therapist shows how a developmentally appropriate interpretation is formulated and that, like a good feed, meets the patient's unmet dependency needs in a way that echoes Winnicott's (1956) good enough mother who in meeting her infant's needs empathically – that is reliably and without language, also meets her infant's spontaneous gesture which is the essence of the true-self.

In other words, by treating the patient's explicit negative transference objectively, allowing it to pass as real, the therapist, like the good enough mother, allows for the maturational processes that in the patient-infant lead to the development of a true sense of self or 'me-ness' to unfold and take shape in a way that eventually provides for the relaxed relinquishing of infantile omnipotence and an emerging capacity for beginning to recognize and accept what is 'not-me' without experiencing the threat of annihilatory anxiety, or as Winnicott (1971) articulates – "to separate without experiencing separation".

It is by meeting the patient's unmet dependency needs that the therapist not only removes the negative transference as a resistance to the therapeutic process but meets the unconscious hope of the false-self in providing the conditions in which true ego development can unfold without impingement and without necessitating the use of the

very defences that define and lock the patient in the kind of pathological state that comes for treatment in the first place (Winnicott, 1960a).

By interpreting the explicit negative transference as non-transference the therapist reinstates the conditions in which the false-self feels safe to hand over it's function of holding the true-self to the therapist and in so doing transforms pathological withdrawal into an organized regression to dependence (Winnicott, 1954c).

In other words, it is by meeting the unconscious wish for symbiosis with interpretations that mirror and reflect the patient's feelings that allow for a moment the illusion of sameness and mark a return to the original success situation of primary narcissism in which state the patient can begin to exist together with the therapist in undisturbed isolation.

Like the good enough mother who in meeting her infant's needs reliably allows id satisfactions to become ego strengtheners (Winnicott, 1960b), it is the therapist who in repeatedly meeting the patient's unmet dependency needs with interpretations that mirror and reflect the patient's feelings does the kind of work that eventually builds sufficient ego strength in the patient to recall the original failure and to get angry about it for the first time (Winnicott, 1955).

In this regard it is striking to note how in removing explicit negative transference material by treating and interpreting it objectively as non-transference the therapist not only restores the setting as a safe environment in which pathological withdrawal is transformed into an organized regression to dependence and the original success situation of primary narcissism, but facilitates the difficult passage from dependence towards independence to take place without impingement.

As Winnicott (1955) explains in this regard, by treating the psychologically 'unformed' patient's anger as objective anger and not negative transference, allowing it to pass as real in other words, the therapist is able to make use of his/her failure and in so doing

allow the patient to use this empathic failure as an example of an earlier one about which to express anger for the first time.

In other words, precisely by not interpreting the negative transference as transference – that is, by not interpreting it away by tracing its infantile roots or attributing it to an/other figure in the past but in accounting for it on the basis of the patient's relation to the therapist as a real figure in the here-and-now, the therapist not only demonstrates empathic understanding of the patient but survives the patient's angry attack without retaliation.

It is in surviving the patient's angry attack without retaliation that the therapist allows the patient to place the therapist-object outside the arena of omnipotent control and in so doing facilitates the steady progress in the sequence that Winnicott (1971, p. 90) describes as, "subject destroys object, object survives destruction (as it becomes external), subject can now use object.

In so far as a 'corrective emotional experience' in the form of good enough adaptation to the patient's ego needs according to Winnicott (1963a) is not enough to effect within the patient a change over from dependence towards independence and achieve the kind of independent status that defines maturity and health, it is the negative transference and working in explicit negative transference as non-transference that plays a central role in doing the kind of work that effects this shift.

It is in fact precisely by interpreting or working in explicit negative transference objectively as non-transference and in using the countertransference to do so – that is, in understanding and interpreting the patient's negative transference objectively as a protest against feeling unsafe, that the therapist not only provides the corrective emotional experience in meeting the patient's unconscious need for symbiosis paradoxically by accounting for having failed the patient in some way, but effects the kind of work that facilitates the patient's transition from dependence towards independence and the capacity for discerning, tolerating and accepting difference.

In this regard it is interesting to note that while both an absence of explicit transference and explicit negative transference manifestations appear to belong to the same order of pathology (i.e., the kind that can be traced to the earliest infant mother relationship prior to Oedipus), the technical difference involved in making implicit transference material explicit by working **with** implicit transference rather than **in** it and removing explicit negative transference as a resistance to the therapeutic process by interpreting it as non-transference seem to belong to the stages in Winnicott's (1960b) developmental sequence from absolute dependence through relative dependence towards independence involving a transformation of pathological withdrawal into an organized regression to dependence followed by facilitating the patient's passage from dependence towards independence.

It seems to be in this sense too that how the therapists work in the absence of explicit transference manifestations – that is, by using the countertransference to establish the setting as a safe environment by working **with** rather than **in** implicit transference material constitutes what therapists R1, R2 and R3 regard as 'preparing the ground' for how they work when transference material does manifest explicitly in the room as a resistance to the therapeutic process.

Working **with** implicit transference material is therefore the way in which the therapists in this study appear to 'prepare the ground' for interpreting or working in explicit negative transference as **non-transference** in the here-and-now **before** treating and interpreting it as **transference** proper in the there-and-then by tracing it's infantile roots and making these explicit to the patient.

It is by working **with** implicit transference material that the therapists in this study provide the patient with the kind of corrective emotional experience in the form of good enough adaptation to need that builds sufficient ego strength in preparation for doing the kind of work required in facilitating the changeover from dependence towards independence.

While it is striking to note that what the therapists in this study actually do, both in the absence of explicit transference manifestations and in explicit negative transference, recalls the historical shift in the role of the countertransference from obstacle to key tool, it is equally striking to note how by **using** the countertransference as a key tool in establishing the setting as a safe environment by working **with** rather than **in** implicit transference material and in restoring the setting as a safe environment by interpreting or working in explicit negative transference as **non-transference**, the therapists not only position themselves to do the kind of work that according to Winnicott (1955) cannot be assumed done in the early history of the patient's earliest infant-mother relationship, but adhere to the classical Freudian principle of maintaining technical neutrality in the process of doing so.

It is interesting to note in this regard from close analysis of the interviews that while the countertransference experience both in the absence of explicit transference and in the presence of explicit negative transference manifestations often involves a strong invitation to act outside of the therapist's usual therapeutic role/stance (i.e., enact), it is precisely by using the countertransference in understanding implicit transference material objectively as the patient's unconscious communication of intolerable feelings and explicit negative transference manifestations as the patient's protest against feeling unsafe that the therapists in this study demonstrate how the countertransference can be kept in check and technical neutrality maintained.

As close phenomenological analysis shows, by using the countertransference in understanding both implicit transference and explicit negative transference material objectively as non-transference first, the therapists in this study formulate what I have called developmentally appropriate interpretations that match the status of the pre-oedipal patient's flawed capacity for discerning subject-object differentiation, fantasy from fact, transference from reality.

It is in formulating developmentally appropriate interpretations that the therapists in this study not only demonstrate how the countertransference can be kept in check

paradoxically by using it in working **with** implicit transference material rather than directly in it or by interpreting or working in explicit negative transference material objectively as non-transference, but how technical neutrality is maintained paradoxically by meeting the patient's ego needs with interpretations that mirror and reflect the patient's feelings in a way that develops within the patient a capacity for becoming conscious of the unconscious and as a consequence integrated ego functioning.

For example when working in the absence of explicit transference manifestations among the kinds of patients whose pathology seems manifest in an area or aspect of their personality that seems isolated, withdrawn and as a result psychologically 'unformed', technical neutrality is maintained by keeping the countertransference in check precisely by using it as a royal road to the patient's implicit transference material and access route to otherwise split off and projected emotional material as well as by using it in making explicit implicit transference material by translating the countertransference experience into words that bring into consciousness the patient's unconscious split off and projected emotional material in a way that the patient can recognize, accept and integrate as his or her own.

It is in other words by working **with** rather than directly **in** implicit transference material and in using the countertransference to do so that the therapists in this study demonstrate how they maintain technical neutrality by meeting the unconscious hope of the false-self in establishing the setting as a safe environment in which the developmental processes that lead to integrated and intact ego functioning can unfold undisturbed and without impingement. That is, without evoking or reactivating the very defences that in the absence of good enough adaptation develop to hide and protect the vulnerable parts of the patient's personality – the very defences that seem to define functioning in Klein's (1946) paranoid schizoid position and that lock the patient in the kind of pathological state that impedes development and leaves underlying parts of the patient's personality psychologically 'unformed', pre-oedipal and manifest in an absence of explicit transference.

Similarly, when working among the kinds of patients whose pathology manifests explicitly as a resistance to the therapeutic process in the form of the negative transference as a protest against feeling unsafe, the therapists in this study demonstrate how technical neutrality is maintained by keeping the countertransference in check by also using it in understanding the negative transference material objectively allowing it to pass as real and in formulating developmentally appropriate interpretations of it that match the status of the integrity of the patients ego by accounting for the patient's relation to the therapist as a real figure in the here and now.

In other words by keeping the countertransference in check by using it in interpreting or working in the explicit negative transference as non-transference, the therapists in this study not only demonstrate how they remove explicit negative transference material as a resistance to the therapeutic process, but how the patient's experience of the setting is restored or reinstated as a safe environment in which the kind of work that Winnicott (1960a) describes in facilitating the changeover from dependence to independence can take place without impingement – that is, in a technically neutral way.

While it is striking to note how in stark contrast to the classical Freudian analyst who maintains technical neutrality by **frustrating** the neurotic patient's infantile wish for love with interpretations that bring news of difference, the therapists in this study appear to maintain technical neutrality precisely by **meeting** the more psychologically disturbed or pre-oedipal patient's ego need for symbiosis symbolically with interpretations that bring news of sameness either by working **with** implicit transference or by interpreting or working in explicit negative transference as **non-transference**.

In other words, it might be suggested that when psychoanalytic work involves the more classical aim of making the unconscious conscious, technical neutrality is maintained as Freud (1912a, 1917a) described doing so by **frustrating** the neurotic patient's **id** impulses with interpretations that bring news of difference – that is with interpretations that trace and make explicit the infantile roots of the patients relation to the therapist as a figure from the past.

In contrast, when the work involves the more contemporary aim of developing within the more psychologically 'disturbed' patient the capacity for becoming conscious of the unconscious, technical neutrality is maintained by **meeting** the **ego** needs with interpretations that bring news of sameness – either by accounting for the patients relation to the therapist as a real figure in the here-and-now or by making explicit implicit transference material with interpretations that make no mention of the patient's relation to the therapist at all (i.e. working **with** implicit transference).

It seems significant to note that while across both orders of work technical neutrality is maintained by keeping the countertransference in check, the means of doing so emerges as being very different between them.

For example, in keeping with the classical aim of making the unconscious conscious among more neurotic patients, while the countertransference is kept in check by frustrating the patient's wish for love with interpretations that bring news of difference, in keeping with the aim of developing within more psychologically 'disturbed' or 'pre-oedipal patients a capacity for becoming conscious of the unconscious, the countertransference is kept in check precisely by using it in formulating interpretations that match the status of the integrity of the patient's ego and meet the patient's ego needs by bringing news of sameness.

In so far as the findings of this study suggest the centrality of interpreting or working **in** explicit negative transference as **non-transference** and working **with** implicit transference material as a function of the extent to which the countertransference can be kept in check by using it in understanding explicit and implicit transference material objectively first as non-transference, it is interesting to note that there are situations in which it is not always easy to do so.

For example when the countertransference is unclear, fraught with anxiety and involves the therapist in a vulnerable state, then as close reading of the interviews shows it is not indicated to interpret or work either in explicit negative transference as **non-transference**

or **with** implicit transference material **until** the countertransference experience has been sorted out, digested, processed or clarified in other words.

In situations where the countertransference cannot be kept in check by using it interpretively because it is not clearly understood, the therapists demonstrate how they maintain technical neutrality non-interpretively and kept their countertransference in check precisely by treating everything the patient brings into the room as non-transference and in understanding it objectively from the patient's point of view without making any reference to the therapist either as a real figure or as one from the past.

It is in this regard that the therapists in this study emphasise establishing the setting as a safe environment non-interpretively and do the kind of work that meets the status of the integrity of the patient's ego by carrying out therapeutic tasks that involve linking past and present experiences without making the transference link, naming feelings, and labelling them. Formulating extra-transference interpretations and commenting on how the patient uses (or fails to use) the therapeutic space play an important role in doing the kind of developmental work that cannot be assumed done in the early history of the patient and in 'preparing the ground' so to speak for interpreting or working in the transference.

On-going supervision and self-analysis play a central role in gaining clarity of difficult countertransference experiences in relation to more psychologically 'disturbed patients and in containing split and projected emotional material until the countertransference can be used in working **with** implicit transference material or in understanding and interpreting explicit negative transference material objectively as non-transference first.

It is countertransference analysis therefore that plays a central role not only in determining whether or not technical neutrality can be maintained by keeping the countertransference in check by using it in understanding the patient's material objectively first as non-transference but in **timing** when it is most appropriate to interpret or work **in** the transference as **non-transference** or when it is appropriate to formulate

interpretations to the patient that constitute examples of what I have called working **with** the transference in contradistinction to working in the transference.

It is interesting to note in this regard that in contrast to the Kleinian tendency to regard and treat everything the patient brings into the room as transference, it is precisely by regarding and treating everything the patient brings into the room objectively as non-transference that the therapists in this study not only maintain technical neutrality by working in a way that matches the status of the integrity of the patient's ego and meets the patient's ego needs in a way that marks a return to the original success situation of primary narcissism, but that in doing so achieve the kind of developmental work that can still be called psychoanalytic without working **in** or **with** transference material and without using the countertransference as a key tool in doing so.

It is in other words by recognizing the countertransference as **both** a key tool and a potential hindrance that the therapists in this study demonstrate their sensitivity to the importance of maintaining technical neutrality and in this regard that the clarity of the countertransference emerges as playing a central role in determining **how** technical neutrality is maintained – that is, whether or not the countertransference can be kept in check by using it interpretively.

As the findings of this study show, in situations where the countertransference is unclear and cannot be kept in check by using it interpretively, technical neutrality is maintained by keeping the countertransference in check precisely by treating and regarding all the 'other' material the patient brings into the room as non-transference without using the countertransference to do so.

It is when working in the absence of explicit transference manifestation among so called psychologically 'unformed' patients, that the setting can be managed and established as a 'holding' environment either **interpretively** or **non-interpretively** depending on the **clarity of the countertransference**.

It is the clarity of the countertransference that in this study determines the centrality of working **with** implicit transference material in a way that brings the unconscious into consciousness and facilitates the development of integrated and intact ego functioning and the clarity of the countertransference that determines the centrality of working in the explicit negative transference as non-transference in a way that **restores/reinstates** the setting as a safe environment in which the patient can separate without experiencing separation and achieve independent status.

While it is striking to note how the kind of work the therapists do both in the absence of explicit transference and in the presence of explicit negative transference, reflects the shift from the classical role of the countertransference as an obstacle to the more contemporary idea of the countertransference as a key tool, it is equally striking to note how it is the countertransference that plays a central role in positioning the therapists to maintain technical neutrality precisely by assuming the kind of role that in some contemporary circles it is argued precludes the possibility of the analyst/therapist's objectivity (Renik 1993).

As close reading of the interviews shows, it is for example precisely by "subordinating" the countertransference to the analytic task (Heinmann, 1950, p. 82; Reich, 1966; Sandler, 1976) – that is, by using it to understand and identify or empathise (Wasserman, 1999) with the patient that the therapists in this study position themselves to use their subjectivity objectively and maintain technical neutrality by keeping the countertransference in check by using it in treating and interpreting the patient's transference material as non-transference first.

In this regard it is interesting to note that in contrast to Owen Renik (1993) for example who bases his argument against technical neutrality on the idea that countertransference enactments are inevitable as a result of the therapist's irreducible subjectivity, the findings of this study suggest that these are the very inevitable empathic failures that provide the therapist with the opportunity for using his/her subjectivity objectively in doing the kind of work that can still be called psychoanalytic and in maintaining technical

neutrality in the process of doing so precisely by not interpreting or working in the transference as transference.

For as Winnicott (1955) explains, by treating and regarding the patient's anger as objective anger and not as negative transference – that is, in regarding the patient's anger as a signal for having failed the patient in some way, the therapist allows the patient to make use of his/her failure as an example of an earlier one about which to get angry for the first time and in so doing to place the therapist outside the arena of omnipotent control. It is in other words by surviving the patient's angry attacks without retaliation – that is, without interpreting it away as transference that the therapist facilitates the patient's difficult passage or changeover from dependence towards independence and allows the patient to separate without experiencing separation.

It is therefore precisely because the therapist's subjectivity is irreducible that the therapist is positioned to use the countertransference constructively in a way that recalls Winnicott's (1956) concept of primary maternal preoccupation and maintain technical neutrality by keeping it in check paradoxically by using it in understanding the negative transference objectively as the patient's protest against feeling unsafe and interpret or work in it, as non-transference.

As the findings of this study show, it is the role of the countertransference as a key tool that not only plays a central role in maintaining the classical principle of technical neutrality but that also determines the centrality of interpreting or working in the transference as non-transference and the centrality of working **with** rather than **in** implicit transference material.

It is the role of the countertransference in working at the level of the patient's ego that results in adherence to Freud's advice to only impart with information when it is close to the patient's ego (Strachey, 1934) and defines what the therapists in this study do as working from surface to depth.

In other words, when working among the kinds of patients with whom integrated and intact ego functioning cannot be assumed, it is the recognition of the countertransference as both a potential hindrance and a key tool that ultimately defines what the therapists in this study do, both in the presence and absence of explicit transference manifestations, as being truly psychoanalytic.

CHAPTER SIX

CONCLUSIONS

In so far as the aims of this study involved exploring how local psychotherapists practice in the absence of explicit transference manifestations among the kinds of patients who never make any directly verbal or affectively intense (either positive or negative) references to the figure of the therapist, the central question with which this project was concerned involved exploring how unconscious or in-depth work is effected in the seeming absence of the tool that defines and distinguishes psychoanalytic practice from all other kinds of psychotherapeutic interventions.

The central aim of this study in other words involved exploring how local psychotherapists practice what can still be called psychoanalytic psychotherapy without interpreting or working in the transference among the kinds of patient's whose pathology seems manifest in an absence of explicit transference.

However, based on close reading of what the therapists in this study actually do both in the presence of explicit negative transference and in the absence of explicit transference manifestations, a key finding emerged in terms of **how** transference material is treated and regarded by the therapists in this study and the importance of working at the level of the status of the integrity of the patient's ego.

The conceptual distinctions between interpreting or working in the transference **as transference**, interpreting or working in the transference **as non-transference** and the idea of working **with** as opposed to **in** the transference when it does not manifest explicitly in the room as a resistance to the therapeutic process but implicitly in the therapists' countertransference in the form of an unconscious communication of split off and projected emotional material emerge as novel findings that play a central role in formulating what I have called developmentally appropriate interpretations or ways of

working in or with the transference and make some contribution towards the existing body of psychoanalytic theory and practice.

As the findings of this study show, it is among the kinds of patients whose pathology seems manifest in both an absence of explicit transference and in the presence of explicit negative transference that the centrality of working **with** the transference and interpreting or working in the transference as **non-transference** respectively emerges as a function of treating and regarding both implicit transference and explicit negative transference material objectively first, allowing it to pass as real in other words and not in regarding it as transference proper at first (i.e., as stemming from somewhere else).

While working **with** and working **in** the transference as non-transference appear to belong to the same order of work, there is, however, a difference between them. For example, whereas working with implicit transference involves making explicit implicit transference material to the patient without any direct reference to the therapist, interpreting or working in the transference as non-transference involves accounting for the patient's negative feelings towards the therapist as a real figure in the here-and-now.

In contrast to classical technique of making the unconscious conscious by interpreting or working in the transference as transference - that is by tracing the infantile roots of the patient's relation to the figure of the therapist and making these explicit to the patient, the therapists in this study demonstrate how they develop within their patients the capacity for becoming conscious of the unconscious either by treating and interpreting explicit negative transference material **as non-transference** – that is by accounting for it in terms of the patient's relation to the therapist as a real figure in the here and now, or by making explicit implicit transference manifestations by working **with** the transference – that is by interpreting the countertransference without directly disclosing it and without making any direct reference to the therapist either as a real figure in the here-and-now or as a figure from the past in the so-called there-and-then.

While adherence to Freud's (1913) technical advice to only interpret or work in the transference when it manifests as a resistance to the therapeutic process is striking, it is equally striking to note how the way in which the therapists in this study do so when the transference manifests explicitly as a resistance to the therapeutic process in the form of the negative transference recalls Winnicott's (1955) advice to treat as objective the more psychologically 'disturbed' patient's anger rather than regard it as negative transference.

For example, by treating explicit negative transference material as objective anger and interpreting it as non-transference – that is, by accounting for it in terms of the patient's relation to the therapist as a real figure in the here-and-now rather than attribute and trace it to an/other figure in the past, the therapists in this study not only remove the explicit negative transference as a resistance to the therapeutic process by formulating what I have called a developmentally appropriate interpretation or way of working in the transference that matches the status of the integrity of the patient ego and capacity for discerning difference, but restore the setting as a safe environment in which the patient can separate without experiencing separation.

In other words, by interpreting or working in the explicit negative transference objectively as non-transference the patient's difficult passage from dependence towards independence is facilitated and the kind of developmental work that cannot be assumed complete in the early history of the patient's infant-mother relationship is achieved psychoanalytically.

While the conceptual distinction between interpreting or working in the transference as transference and interpreting or working in the transference as non-transference plays a central role in defining the difference between doing what can be called conflict and developmental work (Pine, 1992), it is the distinction between what I have called working **with** rather than directly in the transference that plays a central role in understanding how work that can still be called psychoanalytic is achieved without directly interpreting or working in the transference – that is without making any direct

reference to the therapist either as a real figure in the here and now or as an heir to an earlier object relationship.

It is in other words by working **with** rather that directly **in** the transference that defines what the therapists in this study actually do in the absence of explicit transference manifestations and resolves the paradoxical question of how one might effect the kind of work that can still be called psychoanalytic in the seeming absence of the tool that defines and distinguishes psychoanalytic practice from all other kinds of psychotherapeutic interventions.

In so far as working with rather than in the transference answers the question with which this research project was primarily concerned, it is however the relationship between what the therapist in this study do both in the absence of explicit transference and in the presence of explicit negative transference manifestations that not only defines the kind of work that requires something different from the therapist than interpreting or working in the transference in the classical sense of tracing the infantile roots of the patient's relation to the figure of the therapist (i.e., interpreting or working in the transference as transference), but also reflects the changed role in the countertransference from obstacle to key tool.

Despite the conceptual difference between working **with** the transference and interpreting or working **in** the transference as **non-transference**, it is both what the therapists do in the absence of explicit transference manifestations and in the presence of explicit negative transference that belongs to the kind of work involved in 'managing the setting' and the order in Winnicott's (1954c) developmental sequence involving a transformation first of pathological withdrawal into organized regression to dependence followed by a changeover from dependence towards independence respectively.

For example in the absence of explicit transference manifestations, it is the role of the countertransference as a key tool that not only positions the therapists to receive and understand the patient's implicit transference as an unconscious communication and

access otherwise inaccessible areas or aspects of the patient's personality, but to bring into consciousness unconscious split off and projected emotional material in a way that recalls Winnicott's good enough mother who in meeting her infants needs empathically allows for the illusion of primary creativity and omnipotence and existence for a time with the mother in a state of undisturbed isolation.

By using the countertransference as a royal road to the patient's implicit transference in the form of an unconscious communication and in formulating interpretations that give back in words split off and projected emotional material, the therapists in this study demonstrate how they manage the setting by working **with** rather than **in** implicit transference material and establish the setting as a safe environment in which the false-self feels safe to hand over or relinquish its defensive function of holding the true-self to the therapist and facilitate pathological withdrawal into an organized regression to dependence (1954c).

While it is the role of the countertransference as a key tool that not only defines what I have called working with implicit transference as opposed to directly in it and therefore also what the therapists actually do in the absence of explicit transference manifestations, it is precisely by subordinating the countertransference to the analytic task that it is kept in check and technical neutrality maintained paradoxically in the process of doing so.

Similarly, by subordinating the countertransference to the analytic task by using it in understanding the patient's negative transference objectively as a protest against feeling unsafe and in removing it as a resistance to the therapeutic process by formulating an interpretation of it that accounts for the patient's relation to the therapist as a real figure in the here-and-now, the therapists in this study not only demonstrate how they manage the setting by restoring it as a safe environment by interpreting or work in the transference as non-transference but in doing so maintain technical neutrality by surviving the patient's angry attack without retaliation and in a way that facilitates the changeover from dependence towards independence to take place without impingement.

While the findings of this study show how Winnicott's (19550 idea of managing the setting can take place interpretively, it is the role of the countertransference in doing so that plays a central role in demonstrating the somewhat controversial idea of how technical neutrality can be maintained by keeping the countertransference in check precisely by using it as a key tool.

It is precisely by subordinating the countertransference to the 'analytic' task both in the absence of explicit transference manifestations and in the presence of explicit negative transference – that is, when working among the kinds of patients with whom integrated ego functioning cannot be assumed - that the therapist is positioned to maintain technical neutrality by assuming the kind of role that involves 'good enough adaptation' in the form of meeting the patient's ego needs with interpretations that match the status of the integrity of the patient's ego and meet the patient's unmet dependency needs symbolically by reflecting and mirroring the patient's feelings rather than by attributing them away to an/other figure from the past by interpreting or working in the transference as transference.

While the parallels in this study with Winnicott's (1960a) work are striking, it seems equally striking to note how the findings of this study not only lend support to the contemporary idea of an emerging technical common ground across historically competing schools (Wallerstein, 1990), but suggest that this common ground emerges on Winnicottian terrain.

It is the kind of pathology manifest in an absence of explicit transference and seemingly best accounted for in terms of Winnicott's (1960a) conceptualisation of a false/true-self split that not only suggests a context in which divergences from classical and convergences with more contemporary practice emerge as a function of the patient's underlying developmental status, but a context in which adherence to the classical principle of technical neutrality emerges as a function of the changed role of the countertransference from obstacle to key tool when working among the kinds of patients

whose pathology seems traceable to disturbance in the earliest infant-mother relationship prior to Freud's Oedipus.

6.1 Limitations of the present study and implications for further research.

While the findings of this study suggest important implications for theory, practice and training, they derive from the work of only four practicing psychotherapists and cannot therefore be generalized. As such the findings must be considered within the exploratory nature of this project and can only be regarded for the time being as tentative.

Despite the possible contribution towards the existing body of literature on the correctively potentialities of the therapeutic relationship, further phenomenological research is required to explore how psychoanalytic psychotherapists actually practice in the room in the absence of explicit transference manifestations.

In so far as the findings of this study suggest the importance of how transference material is treated as a function of the patient's developmental status and the conceptual differences between interpreting or working in the transference as transference, as non-transference and the idea of working with rather than in the transference, further qualitative research across many more therapists is required in terms of testing these ideas further.

While the phenomenological method of data collection and analysis afforded exploration of how theory translates into practice – that is, how theoretically derived concepts are lived out and experienced in the room by the participating therapists, one of the most practical limitations of this method is the cumbersome and unwieldy presentation of raw data and analysis which, however necessary for the critical reader, nevertheless makes for lengthy and at times tiresome reading (Giorgi, 1989).

Also, since sound phenomenological research depends on the researcher's ability to observe, report and interpret as well as the participating respondents' verbal fluency it is

not certain to what extent the richness of data may have been compromised given my limited experience in conducting phenomenological research as well as the possibility that the participating therapists may have experienced, from time to time, difficulty in expressing themselves within the context of this research and the questions asked. These considerations become particularly noteworthy given the fact that there are multiple meanings of key psychoanalytic concepts across different schools. The translation of theory into practice is therefore not always an easy one and becomes even more difficult to articulate during an interview lasting no longer than 50 minutes or so. Another limitation involved in exploring certain in-the-room phenomena qualitatively relates to ethical considerations around confidentiality and the extent to which the yield of rich detailed clinical data is compromised by tapering it in protection of the patient's privacy.

While every attempt was made to ensure maximum comprehension and understanding so that the reflexive analysis of the interviews remained as true as possible to the lived experience of each participating therapists' experiences of, and thoughts about, practicing psychoanalytic psychotherapy in the absence of explicit transference manifestations, there can be little doubt that my subjectivity, use of language and interpretation may have influenced or changed the observed phenomenon (Giorgi, 1989).

Furthermore, since the analysis of the interviews and the extended description of the participating therapists' experiences are reflected on and expressed in my language, the extent to which another researcher "confronted with the same data, posing the same question will invariably express their findings differently" (Von Eckartsberg cited in Valle, 1998, p. 63), renders the reliability of this study (particularly according to natural scientific standards) necessarily compromised.

However, despite these limitations, the final evaluation of this study will rest on the extent to which: 1) the reader can see what I saw (Giorgi, 1975); 2) the participating therapists' experiences of, and thoughts about, practicing psychoanalytic psychotherapy resonates with the lived experience of other therapists' experiences and thoughts about the same or similar phenomena (Becker, 1987); and 3) whether the description of how the

therapists in this study practice psychoanalytic psychotherapy provides the reader with an improved holistic understanding of the phenomenon (Becker 1987).

In the interests of theory building or more precisely, in proceeding along more established lines of knowledge, while the discussion of the therapists' clinical experiences of practicing in the absence of explicit transference manifestations and placing of the kind of pathology manifest in an absence of explicit transference within the context of Winnicott's (1960a) formulation of a false-true-self split makes for interesting theoretical and practical considerations, the extent to which the findings of this study are deemed credible or useful, will depend, not only on further research in this area, but on the perspective of other researchers who may or may not endorse my viewpoint, and in turn, clinicians who may or may not find the proposed conceptualisations therapeutically useful or relevant.

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