Image Induction in the Countertransference: A Revision of the Totalistic View

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This article presents an integration of psychoanalytic and creative art therapy concepts in an attempt to expand the parameters of what psychoanalysts call "totalistic" countertransference. The totalistic view of countertransference, regression and empathy, and projective identification are described and discussed, followed by a brief section on visual reception in which the author supports the belief of the necessity for making creative art materials available to both the patient and the analyst during the session. When art materials are used, identification and understanding the significance of images can take place. A clinical example (Miss A.) is presented; the patient is a 33 year old artist who began psychoanalytic psychotherapy two years previously, and currently is better able to understand some of the aspects of attachments to a boyfriend and to a clinging mother. Intellectual, disconnected experiences were evident from the patient's past experiences, and the author points out the need—and some procedures—for resolving this disconnectedness. A brief discussion of the case is presented, followed by a summary statement regarding a technique, with appropriate cautions given.

Introduction

A focus of this article is on an integration of psychoanalytic and creative art therapy concepts in an attempt to expand the parameters of what psychoanalysts call "totalistic" countertransference. Although psychoanalysis and creative art may at first seem quite different from each other, they may indeed have much in common and, in fact, complement each other. Freud himself, in his paper *On The Question of Lay Analysis*, comes to the conclusion that psychoanalysis is, in fact, an "art" rather than a science, and people who are themselves especially creative may be the most particularly well disposed to become psychoanalysts (Freud, 1927). Before I present the major theme of this paper, I would like to define several terms which are often found in psychoanalytic literature, but may be used by various authors in different ways. To ensure that the reader understands my particular usage of these terms, and will, therefore, be better able to follow the reasoning set forth here, I offer the following three definitions.

1. The Totalistic View of Countertransference

When Freud first used the term countertransference (Freud), he spoke of the analyst's unconscious reaction to his patient, based upon the analyst's early object internalizations. This was, for many years, considered to be a detriment to the psychoanalytic work and such reactions within the analyst would be understood to indicate a need for the analyst to analyze and work through the personal conflicts which stimulated such reactions, as it was believed they would inevitably interfere with the progress of his patient's treatment. This specific point of view is today called the "classical" definition of countertransference.

However, during the years since this original conceptualization, other authors have written extensively about other types of countertransference reactions which commonly occur in the analyst as he/she works with various types of patients (Kernberg, Masterson, Racker, Robbins, Roland, Searles, Winnicott). These reactions, because of the inevitability of their presence, have led clinicians to believe that less emphasis should be placed upon viewing this phenomenon as the analyst's deficiency, but should be seen instead as a new and unique tool with which we can better understand the patient's transference projections and early object, or self-object experiences.

Some authors point out the necessity for the analyst to be open and receptive to these feeling "inductions," as they inevitably arise in treatment, in order to keep them conscious and not repressed (Masterson, Winnicott, Racker, Bion). It is precisely the repression of such feelings which most often leads to countertransference acting-out, and ultimately to interference with the progress of the patient. This new emphasis then shifts the analyst's attention onto these "inductions," rather than away from them, and encourages the analyst to use them to better understand what is happening within his/her patient and therefore plan more effective treatment strategies.

The term "totalistic countertransference" is utilized to include under

one term all of the various kinds of affective reactions which are found within the analyst—induced reactions and classical countertransference.

While analysts are advised by these authors to constantly examine their affective responses to patients and utilize these feelings in their clinical work, it is beyond the scope of this article to examine how these authors recommend using these feelings. The reader is, therefore, referred to the bibliography for further exploration of specific techniques. My intent here is to add to the currently accepted range of "totalistic" responses one more kind of response within the analyst. This new additional response is in the form of visual images which spontaneously occur within the analyst in response to his/her patient.

2. Regression and Empathy

Regression in the service of the Ego has been commonly cited as a paradigm for both creative experience and the phenomenon which takes place within the analyst as he/she tries to maintain an affective or empathic connection with a regressed or primitively organized patient (Robbins, Kris).

The analyst needs to maintain this affective tie in order for the patient to feel understood, and for new object relationships to develop which can then modify the earlier, pathogenic internalizations. The analyst needs to become a container for, or receptive to, the split-off and projected aspects of self and object which must be externalized by the patient through the transference. The most critical challenge to the analyst is to receive these projections and not allow himself/herself to be transformed or "changed" by them. For further clarification of this process I offer this last definition, projective identification.

3. Projective Identification

"Projective Identification is the mental mechanism whereby the self experiences the unconscious fantasy of translocation of itself, or parts of itself, onto or into an object for exploratory or defensive purposes." (Grotstein, p. 123)

To simplify matters, we will focus upon the exploratory or non-defensive aspect of this phenomenon.

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Within this context, projective identification is best understood as a communication. It is a device through which a patient may externalize the self or parts of the self onto the analyst, with the hope that these projections will be received and experienced by the analyst (so the patient can identify with the analyst) but that they will not damage, change or otherwise transform the analyst into either a victim or persecutor (Grotstein, p. 126).

The key here is that the analyst must receive this projection and in some way acknowledge this receipt. It must then be demonstrated, through behavior, that he/she has not been pathologically transformed by it. In other words, the analyst must allow himself/herself to feel the affective component of whatever the patient has projected onto him or her but the analyst must discipline himself or herself to feel it without acting it out in any way. This process then becomes a model for the patient to internalize. It clarifies for the patient the difference between feeling and acting-out a feeling. The analyst must use his/her expanded ego capacity to facilitate this process. In essence the analyst is receiving, transforming, and ultimately neutralizing the pathogenic energy which the patient needs to externalize if treatment is to be successful.

This leads the patient to a point where the projection is now somewhat neutralized and more readily available for interpretation and subsequent working through. If any step in this delicate sequence is missed, the patient and analyst may never reach this unconscious material in a way which makes it available for analysis, but instead they would either recreate pathological conflicts through unconscious transference and countertransference acting-out, or find themselves bogged down in a didactic, intellectualized discussion "about" feelings. In either case, this would certainly bring the analytic process to a halt.

Visual Reception

Several authors speak of the necessity for the analyst to assume a position of "passive reception" and become a "container" for these projections (Bion, Robbins, Meltzer). It is my belief that, if the analyst utilizes his/her own inner creative resources by making creative art materials available to both the patient and the analyst during the analytic session, he/she may significantly widen the range of reception of these projections to include visual images. These images must then be used within the session and explored in an open and often playful way in order for the patient and analyst to more fully identify and understand their significance. These images may be treated in much the same way as we treat dream images. The patient must be encouraged to associate to not only the image but, also, the affective experience stimulated by such a powerful phenomenon.

The following clinical vignette is offered to illustrate this process.

Clinical Example

Miss A. is a 33 year old artist. She is extremely creative and often uses visual images and metaphors in her treatment to describe feelings which, for her, are difficult to put into words. She began once-a-week psychoanalytic psychotherapy two years ago and, as a result of this treatment has been able to better understand how her current attachment to a boyfriend has been, to some degree, a pathological displacement of split-off aspects of her symbiotic, clinging mother. This material has been coming through in the treatment as an intellectual, disconnected experience and as a result, the patient has not been able to effectively work it through in a meaningful way. She has, therefore, remained cautious and guarded and has had difficulty experiencing trust with her (male) analyst.

During the following session the analyst feels this disconnection, but instead of simply confronting it as a defense (a position taken on many past occasions which inevitably led to a stalemate), he decides to explore it by sketching spontaneous images on his note pad, as the patient drones on. His mental state is one of free-floating awareness as he begins to let his mind roam through the procession of affectless words and piece together visual forms. This mental state begins to feel like a form of meditation as the content of the patient's statements is left behind and his aimless sketches begin to take on a form of their own.

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Without any cue from the analyst, the patient, who cannot yet see what the analyst is doing, reaches for a piece of clay and also begins to make three-dimensional sketches as she continues her monologue. The analyst is now engrossed in his sketch which has taken on the form of a fish with an open gaping mouth. (See illustration) Once again he becomes aware of the patient who has suddenly stopped talking and is now staring at the clay fish which she has unconsciously created! In startled amazement the analyst flips his pad around to show the patient his sketch. She gasps in surprise.

There follows a special moment of silent astonishment where both the analyst and patient share a deeply moving feeling of empathic connection. There is a feeling of excitement in the air. Something profound has just happened.

Miss A. says: "This is a clear case of being connected." What follows is quite dramatic. As if floodgates had been opened, Miss A. began to pour out highly charged associations.

She says: "Fish, water, unconscious, symbiotically connected...to you! I'm connected to you. That large gaping mouth, dependency...it felt so good when you shared your drawing with me, like we shared the feeling of being connected. I'd get a lot more out of this treatment if I'd trust you more. I need to feel that connection in order to trust you."

The analyst interprets how her mother's need for symbiotic attachment to the patient made it frightening for her as a child to feel comfortable with her own developmentally natural need for closeness and intimacy with her mother. He further points out she had been reliving that experience in the transference, being afraid of her dependent feelings as they evolved in treatment.

To this Miss A. responds: "Yes, mother's sign was Pisces, the fish...the gaping mouth is her need to take me in, in order to feel whole. I can sometimes feel this inside me, too. I'm afraid I would need you too much if I ever let this part of me out. Maybe this is why I've kept my distance from you."

In the weeks that follow, this image and experience is often referred to as having changed her in some way.

Discussion

We see here an example of how an analyst fostered an externalization of pathologically internalized aspects of both self and object, by adopting a passive-receptive position in order to transform the patient's projections in a creative way. Any confrontation of the patient's affective withdrawal as purely defensive would have closed off the possibility of this important material emerging. It is both the analyst's acceptance of this position as the receptor and container (Bion, Robbins, Meltzer), along with his own creative ability to synthesize the projection into a visual image, which leads to this most unusual and productive psychoanalytic experience. Of critical importance here is the analyst's understanding of the projective identification process as being a creative, unconscious communication which is offered by the patient to the analyst, in the service of helping the analyst to better understand her.

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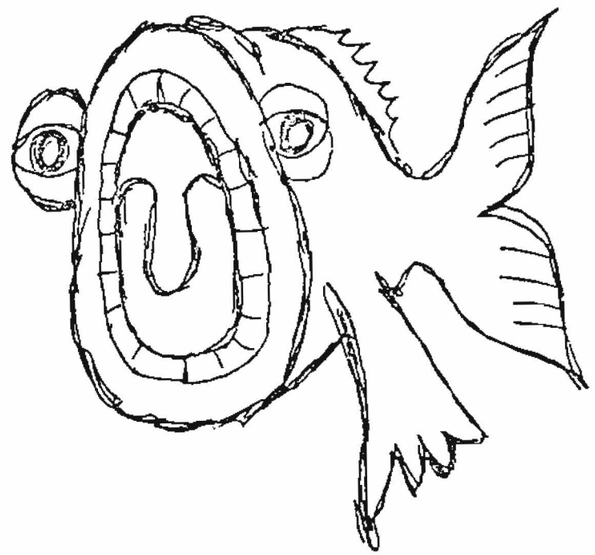
It was also important in this situation for the analyst to show the patient his drawing. This demonstrated to the patient that the analyst did indeed receive the projection, and was not pathologically transformed by it. It is interesting to speculate whether ongoing reception of such projections would eventually cause the analyst to



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mobilize some defense mechanism, if he were not able to neutralize the projection through his own process of creative externalization, in this case drawing. We wonder if, without this vehicle of externalization, the analyst might eventually act out this projection or his affective reaction to the projection in some way. This might be in the form of either playing out the clinging, devouring mother or the patient's unconscious, split-off and projected sense of clinging dependency, the former being the internalized object representation, the latter being the internalized self representation.

It is clear that in this particular case it was important for the analyst to show his drawing to the patient. However, it must also be made clear that acknowledgment of receipt of such projections may sometimes take less direct forms. In fact, the direct sharing of the analyst's art may be far too threatening for many patients. Patients who have had traumatic experiences with early objects that were intrusive and didn't promote a healthy sense of personal boundaries may become quite threatened by the analyst's direct sharing of such material. The experience may become too similar to the feeling that the object is inside of them, and may cause the patient to reinternalize the original traumatic situation.

The challenge here is for the analyst to use these images to put himself/herself on track and become sensitized to subtle shifts in the transference. The analyst may not choose to show the patient *how* he/she understands; what is most important is the demonstration *that* he/she understands, and this the analyst may accomplish in many different ways. He/she may design a variety of interventions, from calmly receiving the projection, containing it and using the knowledge to reaffirm in one's own mind that the overall approach is working, to (on the other end of the spectrum) sharing the image as described above. In fact, for many patients, the analyst's ability to "not respond" may be the most important therapeutic response of all!

One may ask why, in the case above, the sharing was not experienced as intrusive. It is my belief that this kind of intervention will always be, to some degree, a form of acting-out of a symbiotic transference. However, in this type of situation, it led to more cohesion of her sense of self. Why? The reason is based on a paradox. That is, the patient is best able to relate on a symbiotic level and, therefore, needs to be met on this level. To try to reach the patient in an object related way on a higher level would be, and often was in this case, a hollow intellectualized experience. We needed first to meet in a way in which she could connect and then, through the mirroring of the split-off projection, foster a feeling of cohesion for her fragmented self.

From an Ego Psychological perspective, the use of drawing and clay engages secondary process elaboration and fosters a structure within the ego, which binds instinctual energy, making these images less threatening for both analyst and patient. This "ego mastery" experience takes the primary process energy which until now has had a disintegrating effect on the ego, and transforms it into a structure which can now become internalized, thereby strengthening the ego (Horner).

We must also note the possibility that the analyst's image may spring forth more from his own unresolved personal conflicts than from the patient's own psychic material. In this case we may treat it more as a classical countertransference reaction and deal with it as such. However, we must also consider the probability that even in such a situation, there is often some aspect of the patient's conflict which sets off the reaction in the analyst, and if we can understand it and not act-out our personal conflicts, we may still salvage the situation to the patient's advantage.

A true demonstration of effectiveness of any technique must be judged by the patient's behavior and growth.

Summary

I present to you this material which demonstrates such growth in the hope of expanding analysts' awareness of how they can use creative parts of themselves in a new way to help patients grow. It is not my intention to promote this technique as one which should be widely used without careful consideration of its potential dangers. Like any good clinical intervention, it must be woven into a solid treatment structure which reflects both the analyst's personal and professional skills, along with a healthy regard for and understanding of where the patient is and what he/she can use. It is always essential for us to assess what a person is or isn't ready to use in the service of personal growth. In the case described above, the image induction experience became the "keystone" of a phase of treatment. The patient's progress was fueled by the power of the experience. Her profound sense of being understood led to a deepening ability to trust, which had a dramatic effect on her ability to form healthier object relationships.

The importance of the analyst's willingness to utilize creative assets to help decipher split-off projections should be reemphasized. Often it is the limitations of the analyst in receiving deciphering, understanding and creatively using these projections that may lead to an interminable analysis (Robbins). Because of the primitive, nonverbal nature of these projections, an analyst who is most comfortable with his/her own nonverbal, creative processes is perhaps best suited for this kind of intervention.

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