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ALIVE MOMENTS:
A PERSONAL REFLECTION ON WHAT COUNTERTRANSFERENCE MEANS

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Abstract: A reflective piece on Betty Joseph and the notion of countertransference.

For a few years, shortly after I qualified as a psychoanalyst, I attended the Workshop that Betty Joseph ran more or less throughout her career. I did not make much of a contribution to the discussion, as I recall, being perhaps too young and experienced in the business at the time. So I got more from it than I gave, nevertheless what I did give, over the years, has been a commitment to her central idea. I remember on one occasion, maybe around 1980, she said she had been asked about publishing her collected papers, and she had replied (she said), "You mean my collected paper!". In fact her collected papers were published in 1989, as a kind of musical variation on a theme. Her 'one paper' was in 1975, 'The patient who is hard to reach'. It was just be before I had qualified. It addressed a particular form of resistance.

All patients resist their analysis, we all have an unconscious to protect, to the ultimate. As analysts therefore we all flounder in a situation where we assume that our patient's come for the insights we can offer, whilst the patient (at least his unconscious) comes with the intention to find help in supporting his unconscious defensiveness. Being at cross-purposes like this with each other is common enough. What is difficult to keep in mind is that it does indeed happen, and subtle processes ensure that the analyst's consciousness is clouded.

Betty Joseph described particular patients who seemed to resist analysis, just for the sake of doing so. She attributed this to the essentially self-destructive working of the death instinct. Self-destruction takes the form of defeating the psychoanalysis – and the psychoanalyst. Her Workshop was eventually celebrated in a festcschift edited by Hargreaves and Varchevker (2004). In reviewing this collection, I wrote,

The inspiration for the workshop was that there are patients who have in common that they are hard to reach, but appear with varied presentations and transferences. They are united in a common problem; that is, a problem with their relationship with treatment. Typical of these patients is that the problem comes to be expressed in a symptom which appears to be a kind of phobic reaction to the products of the treatment, namely insight. However, from the beginning of psychoanalysis patients have resisted insight. There is nothing unique so far. However, for Betty Joseph, the resistance has a special quality connected with disturbing their balance of mind, their psychic equilibrium. These patients are particularly susceptible to change, even to therapeutic change – or, perhaps, especially to therapeutic change. There is, it seems, both a defensiveness against insights that arouse conflict and pain, and also a perverse resistant destructiveness against what is beneficial, just for the sake of it. This dual nature to the negative therapeutic reaction is not new either, being present in Freud's more pessimistic writings from *Beyond the pleasure principle* (1920) to 'Analysis terminable and interminable' (1937). However, it is at this point that Betty Joseph's originality comes in. She is aware of just how difficult it is for the analyst to manage this double resistance, and points out a technical approach to that difficulty. It is the analyst's difficulty that she is most interested in. The analyst is drawn unwittingly into the patient's difficulty and recruited to play a part in the patient's efforts to maintain his equilibrium through defeating insight. The analyst is recruited against himself, and frequently complies. As Joseph says in her Selected papers,

> … forcing him [the analyst] into a particular role is a constant process going on in the analytic situation … the analyst is in the mind of the patient drawn into the process, continually being used as a part of his defensive system. (Joseph1989: 126)

For Joseph this is a constant process occupying both patient and analyst all the time, so that the whole of an analysis has to be thought of as transference; all the associations are in part a reference, conscious or unconscious, to the immediate transference relationship. This has led to what is now a catch-phrase: 'transference—the total situation'.

> The analyst is required to play a central role, that role being defined by a projective identification into the analyst who is required and unconsciously pressed to conform. The uniqueness of Betty Joseph's approach is the technical implications of this constant process by which the analyst is incorporated into the patient's defensive phantasies in the moment of trying to reveal them. (Hinshelwood 2004: 1298-99)

I have taken Joseph's account as foundational to my own thinking about practice, and have been impressed at how this idea has slowly taken off, over the last 40 years. Not by any means do all psychoanalysts now subscribe to this view of resistance, but increasingly there is an acknowledgement of the truly inter-subjective nature of the psychoanalytic encounter – not so different from any human encounter.

Inter-subjectivity

It puts this approach at the forefront of the debates about the psychoanalyst's involvement in the human encounter. Those debates amongst psychoanalysts do not always achieve harmony. Mostly, the debate is around the balance of responsibility for these intersubjective creations. On one hand, the prime motivator responsible for the dramas enacted between patient and analyst which lead away from the work of insight, is likely to be the patient; he is the one who has (or feels he has) the most to lose if his terrors become conscious. But that collusion is with the active participation of the unconscious of the psychoanalyst. This view moves away from the traditional medical model that simply pathologises the patient, and fits patients to theories of the pathology. Instead it pictures psychoanalysis as a fallible method of investigating forbidden truths, which in the moment of failing reveals those hidden truths.

In contrast is the alternative view in which patient and psychoanalyst catch each other up in a joint engagement. It is almost a 'democracy' of the psychoanalytic session. The founding principle is that engagement itself must occur on terms which appear to be equal. This is an avowed 'intersubjectivity' (e.g. Renik 1998) often adopting the name 'relational psychoanalysis' (Mitchell 1997). There is no core truth into which we must gain insight; rather the capacity to develop intersubjective engagement for its own sake. Such engagement is practised as a human gift not yet acquired by the patient, for whom the psychoanalyst is a kind of mentor. This too

moves away from the pathologising strategy, as the dramas are co-creations of both patient and analyst that need to be practised for their own sake. In a respect for post-modernism, this trend leads away from the view that we seek a nuclear problem in the enactment.

In a sense then we can see how the two diverging trends in psychoanalytic practice might actually rest on more commonality than seems likely. One trend takes the problem of intersubjective encounters as a lack of proper practice, and that psychoanalysis needs to be a special arena to improve inter-subjective encountering. The other sees the play for an inherent disturbance of the need for inter-subjective encounter, and that psychoanalytic practice needs to develop the conscious working through of the unconscious disruptiveness. Both therefore rest solidly on the disruption of the encounter between subjectivities, and the human need to live for such encounters.

I read Joseph's seminal paper on 'The patient who is hard to reach', probably very shortly after qualification. It presupposes there are patients who are easy to reach, and it seemed to me (on the basis of what I have been saying) that easy patient's don't really exist. What Joseph's work has added to psychoanalysis is to understand that there are patient's who resist for the sake of it – and that process with the analyst is itself a gratification for the hidden destruction in the unconscious.

In other words, they destroy for the sheer pleasure of doing so, leading to the differentiation of resistance to protect the unconscious, and the resistance for the pleasure of destructiveness – simply for the hell of it, as we might say. Pursuing, now, Joseph's formulation – the inherent disruptiveness – we are led to a need to differentiate two things. First is when the resistance – or unconscious disruption – arises from a protection of unconscious terrors, and secondly when the resistance arises from unconscious destruction, and is an expression of that destructiveness itself. So the *big* question is how, in practice and in the mid-flow of a session, can we perform that differentiation? Not easy!

We need guidance and landmarks. There are two aids to practice that I can offer. It was many years after my musing on hard-to-reach and easy-to-reach patients that I was struck by a remark of Elizabeth Spillius in her reflections on this whole area of work that Betty Joseph had opened up. Spillius wrote that an analyst

> ...who made interpretations in terms of verbal and behavioural content seen in a rigidly symbolic form... now seems likely to have been detrimental to the recognition of alive moments of emotional contact. (Spillius 1988: 8-9)

This points to the importance of 'alive moments'. This does not mean necessarily when there is a a peak of positive feeling; it can also imply sharp disagreement, or threat and panic, or even denigration, and so on. It seems also that 'alive moments' has implications. The term points to the possibility of dead moments; those moments when live engagement is disrupted and disappears. The descriptive term Spillius used, seems to map onto the essential characteristics of patients who are hard to reach – or easy to reach. Thus, when a patient is reached, a moment of life erupts in the session, and when not reached a sense of deadness lies over that moment. In Spillius' description we can also see a further characteristic. The deadness may be correlated with a particular process – the mechanical interpretation of verbal and behavioural content as symbolic emergences from a static unconscious. Despite Freud's discovery of the meaning of dream symbols, an overemphasis on simplistic symbol interpretation can be deadening – an event that Freud himself disparaged in his claim that a cigar is not always a phallic object.

To exemplify, with one mid-week session, of a middle-aged man, who was difficult to engage with;

> Only infrequently could we get a sense of thoughtful engagement together. He told me of a meeting he had with a friend with whom he was working on a project. The friend did very little towards the project, rarely contributed what he had agreed to do, and was in fact a very unreliable man. However my patient was extraordinarily fond of and loyal to this friend. On this occasion I found myself thinking what an unreliable patient I had, who at times would literally go to sleep on the project I was conducting with him. I felt a mixture of irritation that I was struggling so much to make headway with his analysis. I interpreted this a little mechanically along these lines. I compared how we both struggled to keep a project going, him with his friend, and I with him. He was silent (in fact a common response for him), and then he started snoring (also common)!

No sign of an alive moment in that ... The interpretation had the quality of what one of my supervisors when I was in psychoanalytic training told me was a 'you-mean-me' transference interpretation. That meant the mechanical quality of translating the content onto alternative figures – those playing out the transference.

The complicit analyst

With this failure, we come to the functioning of the psychoanalyst. Centrally the question would be: What happened to the analyst that he used a mechanical mode of thinking? He too was not 'alive', and contributed his share of the deadness of the moment. This is certainly his responsibility, but what might have been the prompts to go in this incorrect direction. The analyst was irritated, and, in my description, conveyed perhaps a sense of hopelessness with this man. It might be supposed that, with charity, the analyst did his best to just keep going. This entailed taking the content, and substituting different figures into the narrative described, just as Freud had done 100 years before in his dream analysis. It points strongly towards the conclusion that a simple content analysis is in fact too simple. What is the missing ingredient?

Fifty years ago Roger Money-Kyrle (1956) described a case; 'A neurotic patient, in whom paranoid and schizoid mechanisms were prominent, arrived for a session in considerable anxiety because he had not been able to work in his office' (Money-Kyrle 1956, p. 362). The analyst made interpretations that were not entirely convincing to himself – or the patient. The patient began to reject them and accused the analyst of not helping, 'By the end of the session he was no longer depersonalized, but very angry and contemptuous instead. It was I who felt useless and bemused' (Money-Kyrle 1956, p. 362-363). Any engagement between them to create understanding died. This case came to mind as it resembles to some extent my own description above. The analyst in some state in which he has to try to keep on keeping on, gets into a process with the patient in which a result became very apparent. This result – only appreciated after the session, Money-Kyrle stated – was that there was a transfer of some feeling of uselessness from the patient who arrived with it and passed it (by making his rejections) into the analyst who went away with it.

The analyst clearly failed, though understandably perhaps. The patient on the other hand was communicating, perhaps in the only way he could; or perhaps he was defensive and off-

loading a noxious experience into some other mind available; or indeed perhaps the communication was intended in a destructive way to harm the analyst and the analysis. Whatever the patient's motivation, for which he is responsible, the analyst is also responsible for the way he handles it, for the best or for the worst. If the analyst fails, there is then a further twist to the screw, because the patient then responds to the analyst who has succumbed to his countertransference. As Money-Kyrle remarked, the process has moved on – 'a new situation arises in which his response to our mood may itself have to be interpreted' (Money-Kyrle 1956: 363).

Money-Kyrle has introduced us to a different field of observation, the process in the session. It is the process of transference and countertransference, but it is not grounded simply on the contents of the associations. The mind of the psychoanalyst needs to pay attention to both – simply one is not enough. Money-Kyrle was writing at a time when countertransference was the topic of heated debate, at least in Britain. The furore was, if not started, stoked by Paula Heimann's two seminal papers on countertransference (Heimann 1950, 1960). She said, on one hand, the analyst is not a blank screen, and nor is he simply engaging in a mutual intersubjectivity. In fact she critiqued both extremes. On the one hand,

> The aim of the analyst's own analysis is not to turn him into a mechanical brain which can produce interpretations on the basis of a purely intellectual procedure, but to enable him to sustain his feelings as opposed to discharging them like the patient. (Heimann 1960: 152)

And on the other hand, the extreme opposite of the mechanistic form of practice, some analysts,

> referring to my paper (in 1950] for justification, uncritically, based their interpretation on their feelings. They said in reply to any query ‘my countertransference’, and seemed disinclined to check their interpretations against the actual data of the analytic situation. (Heimann 1960, [1989]: 153)

In the later paper she argued that the wild use of countertransference needs checking against the content of the free associations. Without the attention to his own feelings, the analyst subsides

simply into a purely mechanical intellect. Clearly the art of interpretation is to do both. The countertransference process impels the liveliness of the session, and the content pinpoints the precise meaning of *that* alive process.

I have given a somewhat personal journey of my discovery of the significance of the alive moments – and the dead ones. I am writing in the tradition spotted by Bob Young:

> The vogue of the concept of countertransference is an index, in my opinion, of a widespread turning away from scientistic models of psychoanalysis based on classical Freudian, neo-Freudian and even so-called contemporary Freudian thinking. It represents a turning *towards* humanistic and story-telling models of the analytic relationship. (Young 1995: 172)

I have rather reversed the usual trajectory starting with Heiman's papers, and moving forward to the Joseph approach and to intersubjectivity. Perhaps this personal account replicates the intensely personal quality of interpreting the patient *in* the session, rather than seeing him intellectually through our theories. In other words, we need perhaps to carry in out minds at every moment, the question, 'Where is the alive moment in this session?'

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