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ARTICLE

Saying Goodbye to Lia. Exploring an Interactive Interpretation of Two Patient-Analyst Systems from a Transference and Countertransference Perspective[1]

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ABSTRACT. – This study investigates the possibility of an interactive model of encounter between patient and analyst and how it may be applied. Interaction in Relational Psychoanalysis goes beyond the traditional transference - countertransference perspective and repositions the subject - therapist experience in a relational framework of encounter. We briefly consider the definition and critical reinterpretation of the Freudian concepts of transference and countertransference.

Keywords: Transfert; controtransfert; relationship; relationship psychoanalysis; analytical report; therapy.

In this work, the words 'analyst' and 'therapist' are used interchangeably, considering that the services of psychoanalysts are sought not merely to give assistance, but also to bring about healing, through therapy. As a consequence, I have disengaged from the timeworn and often obsolete distinction between the terms analyst and psychoanalyst, therapist and psychotherapist. I have chosen to take the respected but rarely-mentioned patient's point of view, although according to Freud (Minolli, 2009, pg. 165) we might legitimately ask ourselves whether the analyst, unlike the patient, really wishes to analyse that patient or, to use a play on words, become his or her therapist.

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[1]This paper is the result of the elaboration of a work dating back a few years ago, developed to discuss the subject at the suggestion of Dr. Michele Minolli, at the school of psychoanalysis of the relationship, revised for its present purpose.

Meeting and relating

Therapy, like life, moves through different stages. People meet, they talk, they relate to each other. As people become more intimate, mutual affection can develop. This affection may follow a gradation from sympathy to compassion, to more or less intense love, or, to antipathy and hatred. This is a normal progression in relationships which anyone can experience, and it ‘normally’ causes no problem. Why, then, does an unproblematic situation change when that relationship is called an ‘analytical relationship’? Are we not still in the presence of two people who meet, talk, relate to each other, and who over time become more intimate?

When Lia came to my study for the first time, after hearing her talk for ten minutes, I felt a warm, sincere affection towards her. I felt a warmth not dissimilar to the kind of affection I have experienced with people encountered in other circumstances. If the manifestation of affection between therapist and patient is cause for concern and a subject for discussion, then a difference between analytical relationships and other relationships exists. For example, in the former, only one of the two people speaks, talks of themselves, of their home, of their life. The analyst mostly listens. Lia was intent on telling me all about her panic attacks, her anxiety, a scared husband, and a mother who would not believe it possible; whereas, I did not talk about that time I had an anxiety problem myself, and nobody noticed, or thought it possible. As a verbal exchange, there is an imbalance in the communication of personal information, albeit what the patient recounts is likely to have been experienced in different forms, ways, or intensities by the analyst. This leads us to a reflection on two levels: on one level, we can ask ourselves whether it is true that by not talking about their own lives analysts do not reveal themselves, and on another level, we can ask what it is that makes affection problematic, or rather, who is affected and why. These two levels intersect to bring other aspects to light. The next sections consider these aspects.

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In an analytic relationship, the patient has an affective investment in the analyst

Through the phenomenon of transference, Freud voices and responds to what others have noticed before him, i.e. the emergence of affectivity and eroticism in the care relationship. Freud claims that this sentimental manifestation is one-way, and attributes it to the patient’s past experiences and emotions which are re-enacted in analysis. Transference is a false link, a thought, a memory, or an impulse that patients project onto analysts in a distorted way. As for analysts, either they must be, or must strive to become a

neutral reflection of this unacceptable impulse or desire. This serves to protect doctors, especially young doctors who are “not yet bound by strong constraints” (Freud, 1918 p. 363) from falling into the trap of exceeding moral limits. It follows that analysts can also be affected by a propulsion which may be strong enough to induce them to violate technical and moral boundaries. What shall we do with transference if its activation is unavoidable and at the same time dangerous? What about the feelings it ‘arouses’ in the analyst? Freud’s attitude towards transference (towards affection and eroticism) is ambiguous: on the one hand, affection is to be supported and acknowledged to the patient, and on the other, the patient is required to renounce it to conform to society’s expectations. The therapist is ‘forced’ to use such means as the power of suggestion: in fact, if the affection-eroticism package is dictated by drive then it is unavoidable (if drive is a biological phenomenon) and the only way to deal with it is to persuade the patient to ‘channel’ it in other directions, thereby sublimating it. The patient thus moves towards a healthier, more acceptable change; configured as conforming to the analyst’s intentions, and at a broader level, representing the demands of society. Submission to society’s expectations can determine individual suffering (Freud, 1929, on the cause of neuroses); however, there appears to be no alternative solution.

However, we said that affection is also the engine of the individual and a value to be supported; the interpretation must partly favor the emotional experience necessary to produce the change (Ventimiglia, 2003). Therefore, we are up against a conceptual problem with transference dictated by its quality of being both good and bad. Its dual nature can be resolved by a further division: the identification of a good, positive transference, and that of a negative and hostile transference (Freud, 1913). Positive transference is composed of affective attachments, and the harmful, hostile kind is defined by eroticism (and its related aggressiveness).

This raises the question: if affection and eroticism are inherent in the relationship, could the therapist be ‘immune’ to it?

In an analytic relationship, the therapist also feels something

As stated above, and in line with Freud’s theory, there can be no immunity from affection as the literature describes how the therapist can be induced to cross ethical limits and must take measures to prevent this from happening. Therefore, we can theoretically assume the onset of some feelings for the patient albeit the feelings are endowed with the characteristics of being an obstacle and caused by the patient; this may be demonstrated by the fact that the therapist would not normally have feelings towards the

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individual who seeks analysis, before analysis. Freud suggests a dual solution to the problem: firstly, therapists have the possibility of removing themselves from risk, with the right tools. Freud claims that with proper training and the right techniques, the therapist can avoid becoming embroiled in these feelings. The therapist abides by rules of abstinence and neutrality for the good of the patient and, I may add, of the analyst. Secondly, therapists are exonerated from responsibility and exempt from being part of what they feel. Moreover, if therapists, like other human beings, have feelings of affection, or erotic and aggressive impulses towards their patients, they may exonerate themselves from blame: countertransference "… arises in him as a result of the patient's influence on his unconscious feelings" (Freud, 1910 pg. 144) and thus the onus is on the patient. In this perspective, the analytic relationship brings with it a real danger of being enveloped by a patient's private affairs and emotions. The danger is so real that they can enter the therapist and act on his or her feelings. However, given their impersonal nature, analysts should be able to recognize and (well?) manage such manifestations, explaining them, distancing them, and returning them to where they belong, i.e. bound exclusively to the patient's experience.

This approach is largely dependent on a program that Freud was dedicated to throughout his life (*Project for psychology*, 1895 for his first work on the subject), *i.e.*, to elevate psychoanalysis to the status of a real, hard science, in line with the positivist movement of the 1800s. It is clear that what we see today is a re-interpretation based on the many developments that have taken place in the field of relational studies. It is equally true that this approach still applies to a certain way of practicing psychoanalysis and being a psychoanalyst. According to the relational perspective embraced by the author, the therapist is placed "outside" a real encounter, inside a shared space, an objectively sound emotional structure, without personal feelings at the sitting, but with a keen, sharp ear, and a watchful eye on that part of the patient to return.

Today, can we still talk of 'healthcare', 'non-involvement', and 'observability'?

Who looks at who and from where?

One of the great teachings of ethology and the social sciences of the eighteenth century is that the observer and the observed lose their neutral and objective nature the moment they become object and subject. The observer does not create reality, but it is utopia to think that if we observe something, even from the corner of a room or from a mirror, we are not already influencing the data/object observed. So why is it that such a com-

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mon and established concept has difficulty penetrating the analyst's room? In other words, could it be out of fear, or advantage (to the analyst) that we somehow choose to believe we can view patients objectively and from a distance, giving back to them only what is theirs?

It is logical that every assumption those referring to analytic therapy, mental suffering, the analyst's room, incorporate a theory of intervention based on a theory of human beings. This provides the lens through which we observe and focus on the point of interest, as well as the instruction manual to do so. From this perspective, it would appear that the standard focus so far described has set the large telescope lens on the patient, and the other end on the analyst's eye, as when an astronomer focuses his attention on a star. However, it would also seem that, in this model, the astronomer forgets that the universe exists and that he, with his telescope, is part of it. This is what happens when we look at transference and countertransference as movements in and of themselves, rather than moments of something more significant going on between two individuals; something we claim to call an analytic relationship. It may be equally obvious that if a subject goes to an analyst, the subject conveys the message to the analyst that 'something is wrong', to be fixed, and requires intervention. This internal observer makes the patient more or less 'good' and collaborative but puts the patient in a less competent position than the analyst who 'sees' and 'knows' with certainty what to do and about what. If we tried for a moment to put patient and analyst on the same plane, what would happen? This operation is legitimate if we think of them as people, and subject to whatever commonly happens to people in an encounter; moreover, as they belong to the same category of human beings, they enjoy the same characteristics. We can attempt this operation using the model of the theory of complex nonlinear systems (Sander, 2002). According to this approach, humans relate to each other as they are, with their history, their evolution, in brief, their self-eco-organizing whole. Each person has reached his or her own level of organization and coherence. Instead of thinking in terms of a healthy individual and a sick individual, better to embrace the idea of two individuals existing in the world and organized in such a way as they have been able. Each of them has a more or less invariant position/quota/portion, a direction (i.e. a more or less recognizable line by which they organize their life), and an open and variable position/quota/mode. We know that each system maintains its organization and coherence and based on this, a continuous exchange between him/herself and the environment. External influences become important and modifying, but internal ones are of equal importance. We must consider that analyst and patient present themselves in this way, for what they are, influencing each other, albeit on different levels and for different reasons. *Infant Research* helps us to explain the individual's subjec-

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tive experience within the dyad and the effect of the dyad on individual experience. The therapeutic relationship is configured as a normal relationship, which becomes 'artificial' as both members have declared a common purpose and objective but shows two individuals in interaction. The analytic relationship maintains the same characteristics as relationships which occur daily, and it can be described using those parameters. Thus, as with any dyad, the analyst-patient dyad is a system in which self-regulation and interactive regulation are integrated. Each member contributes to the exchange in a different way.

This approach shared by other authors (Beebe *et al.*, 2002), sees a new model of transference take shape, a model called "organizational" (a process of organization) also, in some ways, constructivist. In an orientation of this kind, the predominant modality with which we come to see ourselves and others, which in different ways form our experience, is emotional thematic organization. This organizing principle or schematization does not alter 'objective' reality but affects the construction of a subjectively experienced reality. Therefore, transference expresses the patient's experience of the analytic relationship, constructed according to his or her primary organizational schemes and vice versa. Both the patient and the analyst, therefore, participate in the analytic relationship with their own subjectivity through which they interactively construct the analytic experience. Analyst and patient co-determine the relationship and, as with transference, every moment is determined by the different contributions of the two components. The analyst's contribution involves variously problematic organizations that are taken, reworked, and transformed by the patient, just as those of the patient are taken, reworked, and transformed by the analyst. This is what authors, such as Minolli (1993) term "analyst transference". The contribution of each, changes the contribution of the other, and is the product of the contribution of the other. It does not mean, however, that each contribution is determined merely by cause and effect; each partner accepts from the other only what is compatible with his or her own regulation. Another essential aspect concerns quality previously expressed in both the positive and hostile transference proposed by Freud. Not all interactions are characterized by positivity or by the positive nature of emotions and experiences, they also appear to have a functional aspect (Minolli *et al.*, 2007) for the members of the dyad. For this reason, they can also be aversive, although this does not imply that one is better than the other: in the expression of internal motivation in the two systems, the aversive and the positive respond to their own self-eco-regulatory needs. The relationship itself then becomes the object of interpretation. "The only accurate and pertinent observable data is the relationship within a structured field" (Minolli, 1993). If transference represents "... expression of the interac-

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tion between two subjects" (Roggero, 2009, p. 284) which are self- and hetero regulating, it becomes specific to that couple, adding new elements to old solutions. It is clear, therefore, that the objective must be to recognize these specificities to avoid the risk of silently re-establishing existing situations for both, and this is an end.

Being present at what one is and what is happening leads to new meanings and ways of assessing one's position. This is the reflective aspect and constitutes the meta-interactive quality of the analytic relationship, differentiating it from other relationships. Furthermore, in the analytic relationship, one of the two partners explicitly take up the task, the responsibility of analysis, and takes it through its various stages. All this happens notwithstanding both patient and analyst have a stake, and the relationship takes place regardless of the reflective aspect (Minolli, 2009). Considering what has been said, it is legitimate to ask where the affective investment comes from. What should immediately become clear is that it is unrelated to the past, in the sense of a 'false re-activated connection' with the therapist. It is steeped in interaction, and the uniqueness of individuals, and derives from their motivations and level of coherence and organization. While the patient's past is seen as a vehicle for understanding the significance of the relationship now underway with the analyst, therapy consists of an elaboration of the actualized relationship. In this perspective, the patient's and the analyst's responsibility and their active, individual and personal roles, which the classic concepts of transference and countertransference translate to the patient's disadvantage, are restored. Analysts may monitor and share observations of themselves in the relationship for the good of the patient (and their own), and what they feel towards that patient, in addition to the patient's part (Renik, 2006). The analyst's openness is not a factor but a therapeutic tool; it is a guided interaction to serve the purpose of analysis.

How do you say goodbye to Lia?

These reflections convey growth, understanding and 'healing' to both patient and analyst. For greater clarity and completeness, I will relate a short exchange with Lia, a fictitious name for a patient whom I assisted a few years ago. Analysis was to be suspended in June of that year, after a journey of just over three and a half years. During the period of analysis, I alternated from the desire to make Lia feel good, others in which I got angry, or would have cuddled her, others when I would have liked to have had a coffee with her at the bar. Through her words I know all her family, through her stories I have seen each Christmas celebration of the last three years, I witnessed her emotion on her return from enjoying a four-day vacation after five years

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in which panic attacks or the dread of them had prevented her from taking any journey longer than the distance from home to her office (and sometimes not even that). Sometimes, it scared me to hear so much, and I said to myself: *What's going on? Can I work under these conditions?* until I began to understand what Lia meant to me, and I allowed myself to use it with her. In January, it came out, and we began to address the subject: 'saying goodbye', and in that period Lia discovered she was pregnant. A few sittings later she said:

> *"Anyway, don't worry too much, eh? When the baby's born, I'll call you. Don't think that it wouldn't make me happy to tell you about it".*
> *"It would make me happy, too".*

I smiled and was moved. Then I said to her:

> *"Maybe you thought* (author's note: that it would make me happy) *and you wanted to save me the embarrassment of asking?*".
> *"Yes, maybe yes* (laughs). *But also, because it's normal when people help one another to share their joys. I don't know if you have children, but I know what I feel because you have been with me so long".*

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In conclusion, let us look back at one of my questions: is it true that in not talking about their own lives, analysts do not reveal themselves? Every relationship is inter-action, including the analytical one.

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