Chapter 8

Transference/countertransference

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Some general issues

In his *Autobiographical Study*, Sigmund Freud wrote this:

> One day I had an experience which showed me in the crudest light what I had long suspected. It related to one of my most acquiescent patients, with whom hypnosis had enabled me to bring about the most marvellous results, and whom I was engaged in relieving of her suffering by tracing back her attacks of pain to their origins. As she woke up on one occasion she threw her arms around my neck. The unexpected entrance of a servant relieved us of a painful discussion, but from that time onwards there was a tacit understanding between us that the hypnotic treatment should be discontinued. I was modest enough not to attribute the event to my own irresistible personal attraction, and I felt that I had now grasped the nature of the mysterious element that was at work behind hypnotism. In order to exclude it, or at all events to isolate it, it was necessary to abandon hypnotism.
>
> (Freud 1925: 27)

As we know, Freud initially thought he had been experienced as the woman's first boyfriend in adolescence and subsequently came to think that what was being 'transferred' onto him was a feeling for the first love object(s) in the client's childhood. In this autobiographical vignette, there is much on which to speculate from today's vantage point, not least upon what the content of the 'painful discussion' between hypnotist and subject might have been. The roots of psychoanalysis do lie in hypnotism and worries about there being too much 'suggestion' at play in clinical work, leading to the establishment of 'neutral', 'abstinent' and 'blank screen' ways of working stem from this aetiology; thence there is an ongoing professional denial of the part played by suggestion in psychotherapeutic treatment (e.g., Moore and Fine 1990: 196–197). Contemporary relational approaches to psychoanalysis might allow for doubts about Freud's own doubts about his

'irresistible personal attraction'. By now, the therapist's role in the construction of the client's transference is a much theorised phenomenon. I bring in these up-to-the minute considerations as an illustration of my belief (Samuels 1980, 1989) that an exciting and fulfilling way to study the evolution of theory in depth psychology is to begin with the most conflictual and disputed contemporary issues and work backwards, as it were.

It is no mere play of words to state that the very theme of transference-countertransference excites the most extreme transferences and countertransferences. This is true in psychotherapy generally and Jungian analysis may even be seen as a special case illustration of the trend. Intense anxiety surrounds the question of whether Jung did or did not have an adequate conception of transference. Sometimes, he can be understood as dismissing its importance: transference is a 'hindrance' and 'you cure in spite of transference and not because of it' (*CW* 18: 678–679). At other times, such as the moment when he sought to reassure Freud of his orthodoxy (*CW* 16: par. 358), he is very keen to stand up and be counted as a reputable psychoanalyst who has fully understood the centrality of the idea of transference as the 'alpha and omega of analysis'; Freud apparently told him that he had 'grasped the main thing' (see Perry 1997: 141–163; Samuels 1985: 182–183 for a full discussion of this ambivalence of Jung's). Of course, many spiritual directors and doctors had long known about the risks of exciting and responding to amatory feelings in the course of their work and, like Freud in his early years of practice, tended to regard the phenomenon as a danger. Freud may well have been the first to want to know why such processes occurred and he does not seem to have been particularly frightened of them – in fact, with his idea of the 'transference neurosis' he made it possible for therapists to transform what had been seen primarily as a problem into the very thing that made depth work possible. Nevertheless, the penumbra of transference-as-danger remains with psychotherapy and we find even broad-minded psychoanalytic commentators (e.g., Symington 1986: 112) claiming that it is only the painful and difficult things that get transferred; if it is not negative, no need to transfer it. As we will see below, nothing could be more different from the Jungian tradition with regard to transference.

The key role played by transference-countertransference dynamics and understandings in psychotherapy practice reflects a recognition by practitioners that there are many things that are not ordinary about the psychotherapy relationship. But the not ordinary features are, even today, in spite of huge and sophisticated shifts in theory and practice, often boiled down to the apparently inevitable tendency of clients to experience their therapists as parental figures, along Freudian lines. Hence the emotional states associated with transference reflect those of the child–parent relationship – dependency, fear of abandonment, jealousy of siblings, incestuous desire and so on. Jung's insight, often cited by Jungians, that transference is

a natural, multifaceted phenomenon that is widespread in culture is overlooked. In the Jungian therapeutic tradition, there is much more to transference than its infantile or regressive version (see Kirsch 1995: 170–209) and it would be a feature of much Jungian analysis that what look like 'parental projections' would be closely interrogated by therapist and client to make sure it was not a clichéd understanding at work.

The reason why infantile transferences do so often seem to be in play has to do with the nature of what Freud (e.g., 1900: 4–5) called 'primary process', meaning the typical ways in which the unconscious functions, overlooking the rules of space, place and time. The therapeutic space becomes the site of nursing, the therapeutic relationship the place for repair of a nursing experience that did not work out well, and present-day time is overlooked in favour of the time of infancy. It is claimed that the very act of asking for help will constellate or bring into being a regressive, infantile transference – but critics of this view (well summarised in Totton 2000: 134–166) have pointed out that the social structure of the therapy relationship, rather than its assumed morphological similarity to childhood, is also at work; not all seemingly infantile transferences are infantile, many have to do with what is felt about and projected onto psychological experts and mental health professionals (Hauke 1996; Papadopoulos 1998).

Thinking about what lies beyond childhood when it comes to transference-countertransference, Jung was perhaps the first therapist to understand that what the client sees and experiences in the therapist, whether as a positive or negative feature, is connected, via projection, with the client's own self or personality just as it is, as a whole, rather than in its infantile aspects. Hence, an admiring or idealising (in a positive way) transference projection will lead to the client appearing to discover in the therapist aspects of personality – wisdom, tolerance, sensuality, imagination, intellect – that do not belong to, or do not only belong to, the therapist. Here, Freud's 'modesty' is also needed. Post-Freudian theorising about the self and self psychology (e.g., Kohut 1971) has taught us that idealisations are not only negative and defensive features of psychic life. Idealisations are ways in which someone discovers something about him or herself but in a projected form, so that another person carries these qualities. The projection has been necessary because the client is not yet ready to own their own strength and beauty. Maybe this is because they are caught in self-sabotage, or maybe they have had experiences in life that either contradict their more positive features, or make it impossible to claim them. Now, whether the problem is self-sabotage or life experiences such as being born into a poor family and hence not having received much education, a client can quite easily start to experience the therapist as preternaturally wise. Equally often, something different happens and images are projected onto the therapist which make the therapist seem to be a critical, distant, undermining and (socially) supercilious individual.

All of this is transference and *both* the unrealised gold *and* the unrecognised shit of a life will find their concrete form in the lived experience of the transference. The reference to shit is meant educatively because of the need to recall that, in transference projections, the client will often or usually encounter material from his or her own shadow – 'the thing a person has no wish to be', in Jung's words (*CW* 16: par. 470) – but, according to the notion of the shadow, actually is. In the example just given, what if the critical, distant, undermining and supercilious personification is a part of the client's shadow? Much more work needs to be done on the linkages between shadow and transference because of a possible confusion in which 'bad objects' and 'shadow projections' get conflated, especially in the writings and work of those Jungian analysts who have identified very closely with psychoanalysis (wherein there is a huge literature on bad objects but none on the shadow). For example, positive aspects of a person's selfhood can reside in their shadow as well as negative aspects. This has to do with superego functioning (if I might bring in a Freudian concept to amplify a Jungian one). Say a person has had an hyper-religious upbringing in which all lights must be hid under bushels and it is just not 'done' to celebrate oneself. This person will grow up with ordinary and realistic self-esteem in their shadow – and the transference projection will be the first step in the breaking of the shadow's iron grip on the flowering and rounding out of the personality of that individual.

In so far as there is a generic Jungian tradition in connection with transference and countertransference, the following tensions exist within it.

First, there is a tension between an understanding of transference-countertransfernce that gives it an important but *limited* place in any consideration of the therapeutic process as a whole, and one that considers *everything* that takes place in therapy as connected with transference-countertransference and subsumed into it. Proponents of the latter view (everything is transference-countertransference) argue that, due to the special features of the therapy set-up and also the ubiquity of transference as already noted, there is no relationship possible in psychotherapy without an importation of features from outside that relationship. Those who disagree point out that, if everything were to be considered transference-countertransference, there would be little point in having such specialised terminology at all. We could simply refer to 'interactional dialectic' (Fordham 1979: 208) or 'conversation' (Hobson 1985). Terms like transference or countertransference would be reserved specifically for highly neurotic, borderline or psychotic phenomena in therapy.

My own view is that it is necessary to state explicitly what is not transference in the therapy relationship; this provides a sensible basis for delineating what is transferential in the general sense of having been imported into the two-person therapy relationship from the subjectivity of the client. So, again in my opinion, it remains necessary to mention the 'real relationship' or 'treatment alliance' and to distinguish these from the transference-countertransference dynamics of the therapy relationship while allowing for massive overlap and influencing of one kind of relationship by the other. Jung insisted that therapy rests upon a dialectical relationship – i.e., one comprised of a dialogue, important and transforming for both persons and involving a hypothetical equality of the participants, in the sense of spiritually equal in the eyes of God (and, I would add, potentially equal as citizens within the state). This has greatly deepened our understanding of the real relationship and the treatment alliance. Jung is a profound precursor to contemporary psychoanalytic and other interest in the relational base of psychotherapy. Jung's crucial contribution was to stress that both therapist and client are involved in the process as individuals and that both have conscious and unconscious reasons and motives for being there. Implicitly, he raises the complex questions that have increasingly become explicit in contemporary theorising about the clinical process of psychotherapy: what does the therapist do to evoke the transference? And what in the therapist contributes even to a usable (i.e., non-neurotic) countertransference response to the client's transference?

The *second* tension is over the presence of archetypal, as opposed to personal, factors in transference-countertransference material. The discussions on this point quickly become theological. It is said that all transference must be personal, in the sense that only personal expressions of inner world content are possible – i.e., the collective unconscious is indivisible from the personal unconscious (Williams 1963). While intellectually impressive, this position may also be a debating device. For what is usually meant by archetypal transference is that the transference does not emanate from a personal experience – for example, of parenting. Rather, the content that is transferred onto the therapist is of a more general, 'typical' kind. So the wise (or stupid) therapist may be more accurately understood as a transference image to do with the typical, perennial, structuring features (its *sine qua non*) of the healing situation, and not a regressive, personal theme in the client. Certainly, for there to be an experience of a wise or stupid therapist there have to be persons involved. But to claim the whole thing as 'personal' is really a political move given the ideological wars that have taken place in Jungian psychology and analysis since (and before) Jung's death (see Samuels 1985 for an account both reliable and provocative of the division of post-Jungian analytical psychology into three schools: Classical, Developmental and Archetypal; see Young-Eisendrath and Dawson 1997: 89–222 for an extended illustration of what these schools mean in terms of actual analytical and therapeutic practice).

To say that all transferences are truly personal was a mighty fusillade in such a war. On the other hand, it needs to be borne in mind that many apparently archetypal transferences, for example, dreams of the therapist in

an impressive guise as a god-like figure or as the acme of masculinity or femininity may be additionally understood as having personal roots in the presence or absent virtues of parental figures in childhood. Working the field between personal and archetypal transference requires very intricate and flexible interpretative strategies, a capacity in the therapist to stay with confusion and an excess of competing ideas, and an acceptance by all that there is a tension here that resists closure.

The *third* tension concerns whether transference is better understood as a cul-de-sac or blind alley that it may be necessary to explore before turning back, having mapped all its nooks and crannies and feeling able to disregard it as a highway for future development – or whether going into the transference as comprehensively as possible is a road (or *the* road) to further personality integration and individuation. Of course, these two positions are often overlapping and it may be necessary to work on a transference issue for some time, understanding it as something that has to be 'cleared', as it were, and also as tending to promote growth and development. One could express this tension in terms of the difference between 'ghosts' and 'ancestors'. You cannot ignore the ghosts of the past but, once encountered and noted, ghosts may not be as much use in the establishment of a life-enhancing and firm-enough identity as ancestors would be. Transference-driven explorations of the past or of the unconscious situation in the client in the present may play a part in converting ghosts into ancestors, transforming our cul-de-sac into a highway pointing in the direction of psychic richnesses in the future.

The *fourth* tension concerns whether transference is truly a natural phenomenon (as Jung claimed) or more something induced by the therapeutic situation. In the latter viewpoint, there is a cultural and even a political aspect to transference. To my mind, this latter, more socially sensitive understanding of transference is a necessary one and has the added advantage that it does not in any way vitiate the effectiveness of transference analysis as an essential component of healing. But we have to be honest here and accept that whatever we do influences everything that goes on in our clinical settings. If the client is required to attend for analysis four or five times per week, it is disingenuous to claim that the requirement itself has nothing at all to do with the often far greater intensity of transference feeling experienced by such clients compared to the experience of clients in once weekly therapy. Those who advocate intensive analysis of the transference might bear in mind that their advocacy helps to bring the transference into being as a phenomenon originating in the therapist. Extra sessions may not be bringing out features of the transference-countertransference that less intensive therapy fails to bring out; they might be putting something *in* that is very far from being a natural additive. There has been little discussion in psychotherapy generally of these considerations.

The *fifth* tension concerns the interweave between transference projection and 'reality' and how the therapist handles that interweave. Let us say that the client feels that the therapist does not like him. The therapist is aware of this feeling on the part of the client but, search as he might, he cannot find such dislike of the client in himself. It is a transference. (The therapist may be wrong about this and his self-analysis deficient but let us give him the benefit of the doubt for the moment and for the sake of the discussion.) So it is a transference. What is our therapist to do? There are a number of therapeutic strategies he might follow. The therapist may be open to naming the feeling but not to taking this very much further, a state of constructive indifference (constructive because the therapist's theoretical position is that to go into the transference would be a cul-de-sac, as described above), a deliberate decision on the part of the therapist. Or the therapist might recognise that the client has this feeling, accept it without contradicting it but be thinking in terms of exploring and interpreting the feeling (e.g., as a projection) at a later stage. Plaut (1956) referred to this as 'incarnating the archetypal image' and had in mind that the therapist would neither confirm nor deny the feeling in himself, nor explain the mechanisms of transference or projection, nor amplify the material by educating the client via references to the ambivalence of mythological father figures to son figures (Chronos, Uranos, Zeus, Laius, Pharoah, Herod). The next possibility would be to work in the knowledge that this feeling exists and allow for its influence on all aspects of the therapeutic relationship. For example, if the clinical material is somewhat thin, this may be due to the client's reluctance to put forth sensitive and precious things to one whom he feels does not like him.

The last possibility is that the therapist will want to work with this transference for as long and as deeply as seems possible and be alert to related transferences. In fact, the therapist may have long desired such material to emerge, believing, along with James Strachey (1934) and many contemporary post-Jungian analysts, that these here-and-now transferences are gold dust for the clinician. There are many things to consider here. Some have alleged that, far from being a mutative (i.e., change inducing) technique, here-and-now transference interpretations have become an addiction, a sign of hopeless narcissistic preoccupation on the part of the therapist (Peters 1991). Mockingly, references are made to 'you mean me' interpretations (N. Coltart, personal communication 1993). My own position is to try to judge each case on its merits. Sometimes, when the clients refer to a workplace superior who does not like them, they do mean their boss. At other times, a here-and-now interpretation that the boss is a disguised referent for the therapist is valid. In both cases, one hopes that there is some exploration of the client's lifelong and present-day psychological experiences of social superiority and inferiority in the work and other settings but, so it is argued, the incorporation of the figure of the analyst will make the dialogue much more earthy and full of life.

Jung's conception of transference and countertransference

Jung's overall position was that the therapeutic relationship must be distinguished from a medical or technical procedure and that therapy will take a different course according to the particular combination of therapist and client. Hence it is not surprising that Jung's attitude to transference varied so much. As we saw, on the one hand, it is the central feature of therapy and, on the other, little more than an eroticised hindrance to therapy. Jung shows greater consistency when it comes to countertransference and has been recognised as one of the pioneers of a general movement in psychotherapy to regard the emotional, fantasy and bodily states of the therapist as being of importance for a deeper understanding of the client's situation. Up until the 1950s, psychoanalysis, following Freud, tended to regard countertransference as invariably neurotic, an activation of the analyst's infantile conflicts and an obstacle to his functioning (Freud 1910, 1913). To the contrary, Jung wrote in 1929 that 'You can exert no influence unless you are subject to influence . . . The patient influences [the analyst] unconsciously . . . One of the best known symptoms of this kind is the countertransference evoked by the transference' (*CW* 16: par. 163). In sum, Jung regarded countertransference as 'a highly important organ of information' for an analyst (par. 163). Jung accepted that some countertransferences were not so benign, referring to 'psychic infection' and the dangers of identifying with the patient (*CW* 16: pars. 358, 365).

Contemporary post-Jungian analytical psychology has assiduously pursued this interest of Jung's in countertransference as usable in the service of the client's development. For surveys of this see Samuels (1989: 147–159) and especially the outstandingly comprehensive review by Sedgwick (1994). Let me give a flavour of such thinking by outlining my own position, which owes much to Dieckmann (1974), Fordham (1978), Plaut (1970) and Schwartz-Salant (1984).

We can state that there are numerous countertransferences that are not primarily neurotic on the part of the therapist without ruling out the existence of an omnipresent neurotic 'bit', even in such usable countertransferences. My thinking is that there are two rather different sorts of clinically usable countertransference, though both may be seen as communications from the client, who is therefore an ally in the work in this respect.

Suppose, after a session with a particular client, I feel depressed (this may be a single occurrence or part of a series). Now I may know from my own reading of myself that I am not actually depressed and certainly not seriously depressed. I may conclude that the depressed state I am in is a result of my close contact with this particular client. It may be that the client is feeling depressed right now and neither of us was aware of it. In this instance, my depression is a reflection of his or her depression. I call this phenomenon (my depression) an example of 'reflective countertransference'.

But there is another possibility. My experience of becoming a depressed person may stem from the presence and operation of such a 'person' or personification in the client's psyche. The client may have experienced a parent as depressed, and my reaction precisely embodies the client's emotionally experienced parent. I have become part of the client's inner world. I emphasise 'inner' here because I am not attempting any kind of factual reconstruction that would discover a depressed parent. Sometimes there is no person as such. Indeed, the depressed parental image may be symbolic of a depressive theme active in the client's psyche – the client may project his current, present-day depression onto the past, onto the historical figures of his parents. This entire state of affairs I have come to call 'embodied countertransference' and I distinguish it from reflective countertransference.

In this model, considerable emphasis is laid on the distinction between, on the one hand, my reflecting of the here-and-now state of my client, feeling what he or she is unconscious of at the moment, and, on the other hand, my embodiment of an entity, theme or person of a long-standing inner world nature. However, one problem for the analyst is that, experientially, the two states may seem similar and perhaps many usable countertransferences are both reflective and embodied.

Though this is just one model among many, I think many Jungian analysts and therapists who have considered countertransference have become aware that what has been termed 'the countertransference revolution', in which practitioners are legitimised in regarding their own subjective states as somehow linked to the client's, may have gone too far. Perhaps we have become a bit too glib and facile in connection with usable countertransference communications and our wish to be in a state of readiness to work with our countertransferences. Maybe we have pulled a power ploy on some clients by understanding our depression as a communication of their depression, and there are other problems as well. (I drew up a list of the problems with understanding countertransference as 'an important organ of information' in Samuels 1993: 45–46.)

Alchemy as a metaphor for the therapeutic process

It would be mistaken to take Jung as preoccupied with the relational dimension of therapy to the exclusion of an internal exploration of the unconscious on the part of both persons involved. Rather, Jung's particular contribution may be to have found ways of combining the 'one-person psychology' of Freud in which making the unconscious conscious is the main thing and later, two-person psychologies which, in diverse ways, stress the importance of the relational dimension of psychotherapy. Jung chose a

metaphor by which to manage this combination of the interpersonal and the intrapsychic aspects of therapy and his choice has baffled many outside the Jungian professional community. Why choose *alchemy*, of all things, as the root metaphor for the healing process of psychotherapy? Why did he make his most important book on the transference take the form of an elaborated and expansive commentary on a sixteenth-century alchemical tract, the *Rosarium Philosophorum*?

Jung thought that alchemy, if regarded metaphorically, was a precursor of the modern study of the unconscious and therapeutic concern for the transformation of personality. The alchemists projected their internal processes into what they were doing and what they were doing was as much psychological as scientific, according to Jung. Alchemy, in its heyday between 1400 and 1700, was a subversive and often underground current in culture and, in this sense, had a similar relationship to Christianity to the one psychoanalysis developed in relation to Victorian bourgeois morality.

Alchemists had two aims. First, to create something valuable out of base elements in themselves of little value. This is sometimes expressed as 'gold', or 'the philosopher's stone'. Second, to convert base matter into spirit, freeing the soul from its material prison. The connections between these aims and the typical aims of therapy seemed to Jung to be clear. And the interpersonal or relational factor was also present in the alchemical process. The alchemist, usually represented as a male figure, worked in relation to another person (sometimes real, sometimes an imaginary figure), called the *soror mystica*, mystical sister. That is to say, the alchemist needed an 'other' with whom to relate to get his work done at all. There would be no therapist without the client. The alchemist's use of an 'other' may be compared with what Lacan (1949/1977) called the 'mirror stage' of development and to Winnicott's emphasis (1967) on the mother's reflection to an infant of his or her own worth. (See Papadopoulos 1984, 2002 for a groundbreaking review of the theme of 'the Other' in Jungian psychology.)

Putting these perspectives together, one can see how alchemy does manage to straddle the divide between intrapsychic and interpersonal dimensions of therapeutic process and many of the key terms of alchemy find resonance in therapists who feel comfortable with such a wide deployment of one particular metaphor. For example, the *vas* or sealed alchemical vessel puts one in mind of the containing aspects of the frame within which therapy is constructed. The *coniunctio*, an important alchemical symbolic image of sexual intercourse between a man and a woman, refers metaphorically to the deep and pervasive intermingling of the two personalities involved in therapy. At the same time, the image of the *coniunctio* depicts in dramatic form the movements between parts of the unconscious psyches of both therapist and client (Figure 8.1).

The various stages of the alchemical process suggest to a therapist aspects of the therapeutic process: *fermentatio*, when something is brewing up as

Figure 8.1

the 'chemical' reactions of the therapy process get under way, involving changes in both participants; *nigredo*, a darkening of mood and a realisation of the problems ahead, often taking the form in therapy of a depression occurring soon after its commencement; *mortificatio* – something must die in the client (i.e., change, wither away, shift) and probably in the therapist as well before any healing or change is possible. This is but a partial list of the parallels, intended to whet the reader's appetite. (For a fuller treatment of the topic of alchemy see Samuels 1989: 175–193; Schwartz-Salant 1995; and Chapter 12 by Stanton Marlan in this volume.)

The explicitly sexual nature of the illustrations to the *Rosarium* may puzzle many readers who have not grown up, so to speak, within the Jungian world. Sexuality, intercourse, anatomy, are all intended to be taken as metaphors for aspects of psychological development. Hence eros and psychological transformation are connected. But what does 'eros' mean in Jungian psychology and why is an understanding of the term so important for an understanding of Jungian attitudes to transference and countertransference?

Rather like Freud, Jung uses 'eros' in a variety of ways. Sometimes he equates eros with sexuality or eroticism (*CW* 7: pars. 16–43, written as relatively late as 1943). More often, he writes of eros as an archetypal principle of psychological functioning – connectedness, relatedness, harmony and named for Eros the lover of Psyche and son of Aphrodite. Sometimes the principle of eros is referred to as a 'feminine' principle and this implies a complementary relationship with a 'masculine' principle, logos – the word, rationality, logic, intellect, achievement). Jung's use of 'masculine' and 'feminine' is of course problematic and this becomes marked when he assigns eros to females more than to males. Setting that

fiery argument on one side for a moment (but see Rowland 2002; Samuels 1989: 92–122 for discussion of the matter), the point for us here is that *transference-countertransference dynamics and understandings cannot be insulated from eros*. Later, in a section on sexual misconduct, I raise the question of therapeutic work being conducted in reaction and over-reaction to a fear of committing sexual misconduct so that there is a deficit of eros therein, rather than the better-known problem of there being an excess.

The wounded healer

Once we heed Jung's dictum that the therapist is 'in' the therapy as much as the client is, it is possible to begin to theorise about what this might mean. Jungian analysis and therapy has functioned for many years as a laboratory in which the practitioner's role has been scrutinised more thoroughly than in other schools of depth-psychological therapy. As mentioned earlier, therapy is more than a relational process. Each participant has inside themselves a ceaseless unconscious–conscious dynamic or relationship. This means that in a consideration of the therapeutic process one has at least three important relations to consider – the interactive one, and the two internal ones. Critically, *all three are going on simultaneously*.

Being 'in' the therapy also emphasises the woundedness of the therapist. When referring to the idea of 'the wound healer', there is more involved than the ordinary idea that therapists are damaged persons who have become therapists for good unconscious reasons of their own. The idea of the wounded healer implies that the therapist must be wounded, recognise that, and do something constructive stemming from those wounds in relation to the client. Although the notion is present in Jung, the contemporary writer who has best expressed this phenomenon is the psychoanalyst Harold Searles (1975) in his seminal paper 'The patient as therapist to his analyst'. Searles reminds us that healing or helping others is a part of mental health. Hence, when working with a client, the therapist will be aware that the client needs opportunities to help or heal the therapist – without such opportunities, a crucial part of the client's potential cannot develop. The therapist cannot 'play' wounded so as to provide a practice opportunity for healing on the part of the client; he or she really has to be wounded. And, logically as well as psychologically, the therapist has to be open to the possibility of really being healed by the client which may mean accepting at depth that the client's perceptions, far from being 'transference projections', may be accurate. In that earlier example about the client who feels his therapist hates him, the therapist may not reach an insight about the hate within him towards the client that may truly be present without asking himself whom the client reminds him of in his personal history or in his present circumstances, or what it is that he envies in the client.

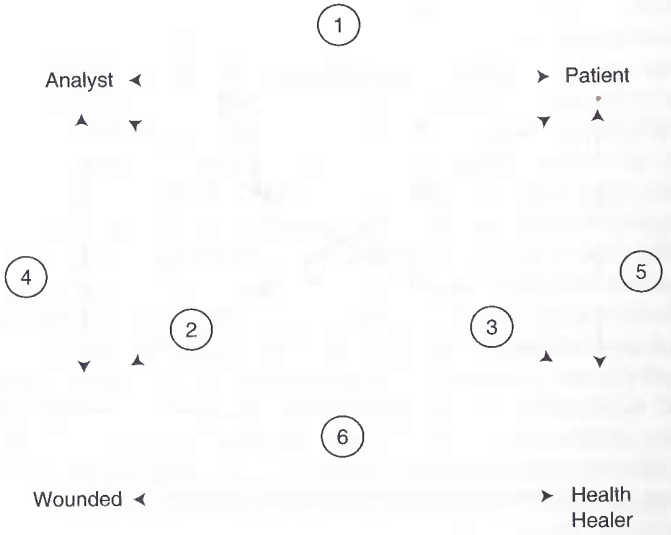

Figure 8.2

Jung presented his ideas on the synthesis of the relational and internal dimensions of therapy in the form of a diagram and many Jungian analysts, including myself, have refined his diagram (see Figure 8.2).

Arrow 1 indicates the conscious connection between therapist and client, where we can see the treatment alliance and the social linkages that make therapy possible. I think that Jung's insistence that analysis be carried out face-to-face, whether taken literally or more metaphorically as a kind of humane principle, means this arrow is much more important than at first seems to be the case. This is the locale for confrontation with the other that was mentioned earlier and sits at the heart of any therapeutic encounter, whether in a consulting room or not. I think it is an important tenet of Jungian analysis and therapy that, in addition to the members of the nuclear family, the client can also be the therapist's ally, enemy, supervisor, therapist, fellow citizen, master/mistress and, on occasion, soul mate.

Arrows 2 and 3 refer to transference projections from the unconscious of therapist and client onto the consciously perceived figure of the other. The therapist projects his or her wounded parts onto the client. The client projects his or her healthy/healer parts onto the therapist. These benign projections seem to me to be the way that therapist and client come to recognise each other *qua* therapist and client. Without these projections, there would not be the heightening of relational tension that makes the therapeutic encounter in some difficult to define way different from an ordinary relationship.

But what happens in arrows 2 and 3 rests to a great extent on what happens in arrows 4 and 5. Arrow 4 signifies the therapist's connection to his or her personal wounds. This should not be limited to whatever has gone on in the analyst's personal analysis (though it is significant that, as Freud (1912) noted, it was Jung who was the first to call (in 1913 – *CW* 4: par. 536) for compulsory training analyses, now a feature of almost every psychotherapy training in some form or other). Rather, we are referring to the therapist's whole apperception of his or her life. Arrow 5 is intended to refer to the client's gradual understanding of his or her potential to be other than a client. The client needs to get in touch, over time, with his or her healthy/healer parts, not only to be able to project them onto the therapist as part of an idealising transference. For there is also the important issue I mentioned earlier – helping and healing others as part of mental health.

Arrow 6 indicates the underlying unconscious connections between therapist and client; this is the level of relationship whose existence makes the idea that countertransference is usable in the client's service possible in the first place. (See the discussion about this, above.)

Some specific issues in connection with transference-countertransference

In the remainder of the chapter, I focus on some specific issues. These are:

- how transference-countertransference dynamics can lead to sexual misconduct on the part of therapists
- transference and countertransference in supervision
- illness in the transference and, in particular, the countertransference
- power issues in connection with transference and countertransference with special reference to transcultural situations
- transpersonal aspects of transference-countertransference.

In the section on alchemy, I included the woodcut from the *Rosarium* that most graphically illustrates the way in which the therapeutic relationship is a kind of marriage with many features in common with such an intense and all-encompassing relationship. It goes without saying that Jungian analysts and therapists do not intend their deployment of such an image to be taken as offering anything other than a metaphorical, as opposed to concrete, comment on the nature of therapeutic work. Nevertheless, in Jungian analysis and therapy, as well as in other approaches to psychotherapy, incompetence and inexperience in handling and understanding processes of transference and countertransference do sometimes lead to *sexual misconduct* on the part of the therapist. This phenomenon must be expressed in such a way – 'sexual misconduct on the part of the therapist' – because, no matter how willing the client might be to enter into a sexual relationship

with the therapist, it is by now understood that, despite rationalisations to the effect that there are transferences in all marriages, it is the responsibility of the therapist to conduct the therapy in a continent way.

That said, as I hinted earlier, there is a problem which is the mirror image of sexual misconduct when the therapeutic relationship is overly deprived of some kind of 'erotic' content – meaning something in the areas of warmth, intimacy, intensity and trust rather than overt sexual expression. We must learn to recognise erotic deficit in therapy as well as erotic excess (and the same will be true in families as well, see Samuels 2001: 101–121). It is therefore desirable that considerations of transference and countertransference continue to incorporate psychological explorations of the 'sexual chemistry' or lack of it of the participants. Post-Jungian writers (e.g., Rutter 1989), have been explicit in raising these issues because of a tendency among Jungian analysts of earlier generations (now greatly reduced to the point where the problem is no more serious than in any other school of psychotherapy) to ignore the pitfalls and dangers of rendering concrete what needed to stay on the metaphorical level. It was no accident that among the earliest features of the transference noted by Freud, it was the sexual and loving aspects that caused the greatest difficulties whether of management or understanding. No discussion of transference-countertransference should overlook this segment of the theme and, given the relationship between sexual misconduct and professional ethics, it has become clear that there is an ethical aspect to work that involves an understanding of or working with transference-countertransference dynamics (see Solomon 2000).

Moving on, the second specific topic I would like to address is how the transference-countertransference dynamics of the therapy couple may be addressed in *supervision*. One way, of course, would be for the supervisee simply to present the transference-countertransference material to the supervisor, who would add his or her understandings to those already developed by the worker. Another way, which I think represents the state of the field at the present time, is for the supervisor and supervisee to accept that what is happening in their relationship parallels what is happening in the therapeutic relationship. Sometimes parallel process takes the form of a straight parallel between the transference developed by the supervisee in relation to the supervisor and the countertransference of the supervisor to the supervisee. At other times, the situation will be much more fluid and the relational and intrapsychic themes, feelings, images passing between supervisor and supervisee will have to be scanned in more general terms so as to elucidate what it is they reflect in terms of the transference-countertransference dynamics of the 'official' case.

The theory behind this approach to supervision is that, when one affectively charged relationship is present within another affectively charged relationship (for whatever reason, supervision being but one illustration of the general phenomenon), there will be an overflow of content and dynamics

of one into another. This has led to the phenomenon in Jungian and other professional circles of case discussion groups in which transference-countertransference dynamics pertaining to a case under discussion are recognised and elucidated by reference to what is happening within the case discussion group itself. (See Mattinson 1975 for a full account of the 'reflection process' in supervision.)

Regarding the next specific aspect of transference and countertransference, I would like to float the idea that there are genuine risks involved in working with this material in terms of *the psychological and even physical health of the individuals involved.* Here, I am thinking particularly of illness in the countertransference and of the vulnerability of the therapist. Later, I will discuss the power of the therapist. Though many experienced practitioners know about this aspect of transference-countertransference, not much has been written about its role in the production of illness. Therapeutic work is exceedingly stressful for both participants and both are subjected to the usual range of stress-related, psychogenic and psychosomatic illnesses, ranging from disorders of the musculature and the skeleton (the 'bad back' so many therapists suffer from) to heart disease, arthritis and, maybe, some cancers. Not nearly enough research has been done into this topic but, in the intense states of mutual persecution and mutual longing that can arise within the transference-countertransference relationship there may lie some seeds of illness. Recognising this phenomenon and working it through may offer very valuable experiences for therapist and client. Clients are by definition vulnerable; let us not forget the vulnerability of the therapist in which the permeability of his or her ego boundaries that permitted the transference projection to penetrate also contributes to a real and sometimes awful suffering caused by the projection.

The fourth specific issue was *power*, with reference to transcultural situations. Most analytical trainings, and many in psychotherapy generally, do not pay sufficient attention to questions of power. In fact, power is an ubiquitous element in therapy (and sexual misconduct may additionally be understood as an abuse of power deriving from the transference of the client). It is tempting, for the liberally minded people who tend to become therapists, to balk at the idea that, in the conscious and unconscious minds of their clients, they are exceedingly powerful, that this power can be experienced as malign as well as benign, and that, far from being 'Terrible Mothers' or 'Archetypal Fathers' in the transference, they are closer to being experienced as torturers, jailers or cruel arbiters of social hierarchy. When there is a transcultural element to therapy (in succinct terms, when the client is from a different cultural/ethnic background to the therapist), these power dynamics intersect with transference-countertransference issues in a bewilderingly complicated manner. For what might be transferred in the case of a person from a minority ethnic group, receiving therapy from a person of the majority ethnic group in a locale, is the former's entire

experience of living under the sway of the majority culture. It is not a personal transference, more of a 'group transference' but the experiences will also have been highly personal, maybe involving prejudice, discrimination and humiliation. How could such experiences not lead, in some cases, to the expectation of a repeat performance in therapy? Nor are these transferences 'archetypal', in the sense of being perennial and typical because such transferences (and the concomitant countertransferences involving unconscious and conscious assumptions on the part of the therapist about a member of such-and-such an ethnic or national group) originate in social organisation and the time-bound political arrangements within a society.

The last specific aspect of transference-countertransference I wanted to discuss was the *transpersonal* aspect. There are many ways to approach this topic which, until recently, with the rise of a transpersonal strand within humanistic and integrative psychotherapy, was a field in which the Jungian presence was overwhelming. The intensity of relational energy in a transference-countertransference situation does give the participants a sense of accessing something beyond what is involved in an ordinary relationship. Clearly, one has to conceptualise this with great caution lest one be seduced into an inflated assessment of what therapy is capable of. Nevertheless, there is undoubtedly a relational dimension that adheres to the transference-countertransference dynamic that is 'larger' than in an ordinary personal relationship. Some, including myself, would argue that this is indeed a simulacrum and a reprise of a relation to the divine. More sceptical and rationalist readers may find this point of view off-putting but numerous writers (e.g., Ulanov 1995) have offered their own narratives of how the therapy conversation moves, seemingly of its own volition, in transpersonal and 'spiritual' directions when the intensity of the transference-countertransference dynamic is not unduly resisted. What is interesting is that the same clinical phenomena – transference-countertransference dynamics – lead *backwards* to origins and roots and *forwards* to an enhanced practical spirituality accessible by both participants in therapy. The alchemists did their work in a *laboratorium* and contemporary pictures and illustrations show us a room or cell recognisable as a modern 'lab'. If the alchemist is a medical alchemist (or 'iatrochemist'), then one can see the clients receiving or waiting to receive their treatments. But the alchemists also prayed for the success of their work in another room – an *oratorium* and written above the door they posted the words *Deo concedente* – God willing.

Mention of divine intervention leads to the following concluding thought: in our concern for the less obvious aspects of the analytical relationship, referred to as transference-countertransference, and clearly the province of the analyst as an expert, we should be careful not to exaggerate the importance of a technical approach. An exaggeratedly professional attitude not only misses the humanity of the analytical encounter but also

leads to a state of hubris or inflation on the part of the analyst that can injure the work that she or he believes in.

References

Dieckmann, H. (1974) 'The constellation of the countertransference', in G. Adler (ed.) *Success and Failure in Analysis*. New York: G.P. Putnam's Sons.

Fordham, M. (1978) *Jungian Psychotherapy: A Study in Analytical Psychology*. Chichester: John Wiley.

—— (1979) 'The self as an imaginative construct'. *Journal of Analytical Psychology*, 24(1): 18–30.

Freud, S. (1900) *The Interpretation of Dreams. Standard Edition* 4 and 5. London: Hogarth Press.

—— (1910) 'The future prospects of psycho-analytic therapy', in *Standard Edition* 8. London: Hogarth Press.

—— (1912) 'Recommendations to physicians practising psycho-analysis', in *Standard Edition* 12. London: Hogarth Press.

—— (1913) 'The disposition to obsessional neurosis', in *Standard Edition* 12. London: Hogarth Press.

—— (1925) *An Autobiographical Study*, in *Standard Edition* 20. London: Hogarth Press.

Hauke, C. (1996) 'The child: development, archetype, and analytic practice'. *San Francisco Jung Institute Library Journal*, 15(1): 17–38.

Hobson, R. (1985) *Forms of Feeling: The Heart of Psychotherapy*. London and New York: Tavistock.

Kirsch, J. (1995) 'Transference', in M. Stein (ed.) *Jungian Analysis*. La Salle, IL: Open Court.

Kohut, H. (1971) *The Analysis of the Self*. New York: International Universities Press.

Lacan, J. (1949/1977) 'The mirror stage as formative of the function of the I as revealed in psychoanalytic experience', in *Ecrits*, trans. A. Sheridan. London: Tavistock.

Mattinson, J. (1975) *The Reflection Process in Casework Supervision*. London: Institute of Marital Studies.

Moore, B. and Fine, B. (eds) (1990) *Psychoanalytic Terms and Concepts*. New Haven, CT and London: Yale University Press.

Papadopoulos, R. (1984) 'Jung and the concept of the Other', in R. Papadopoulos and G. Saayman (eds) *Jung in Modern Perspective*. London: Wildwood.

—— (1998) 'Jungian perspectives in new contexts', in A. Casement (ed.) *Post-Jungians Today: Key Papers in Contemporary Analytical Psychology*. London and New York: Routledge.

—— (2002) 'The other other: when the exotic other subjugates the familiar other'. *Journal of Analytical Psychology*, 47(2): 163–188.

Perry, C. (1997) 'Transference', in P. Young-Eisendrath and T. Dawson (eds) *The Cambridge Companion to Jung*. Cambridge: Cambridge University Press.

Peters, R. (1991) 'Transference as a fetish'. *Free Associations*, 35: 56–67.

Plaut, A. (1956) 'The transference in analytical psychology', in M. Fordham with others (eds) (1974) *Technique in Jungian Analysis*. London: Heinemann.

Plaut, A. (1970) 'Comment: on not incarnating the archetype', in M. Fordham with others (eds) (1974) *Technique in Jungian Analysis*. London: Heinemann.

Rowland, S. (2002) *Jung: A Feminist Revision*. Cambridge: Polity.

Rutter, P. (1989) *Sex in the Forbidden Zone*. London: Unwin.

Samuels, A. (1980) 'Fragmentary vision: a central training aim'. *Spring*: 215–225.

—— (1985) *Jung and the Post-Jungians*. London and Boston, MA: Routledge and Kegan Paul.

—— (1989) *The Plural Psyche: Personality, Morality and the Father*. London and New York: Routledge.

—— (1993) *The Political Psyche*. London and New York: Routledge.

—— (2001) *Politics on the Couch: Citizenship and the Internal Life*. London: Profile; New York: Other Press.

Schwartz-Salant, N. (1984) 'Archetypal factors underlying sexual acting-out in the transference/countertransference process'. in N. Schwartz-Salant and M. Stein (eds) *Transference/countertransference*. Wilmette, IL: Chiron.

—— (1995) 'Introduction', in N. Schwartz-Salant (ed.) *C.G. Jung on Alchemy*. London: Routledge; Princeton, NJ: Princeton University Press.

Searles, H. (1975) 'The patient as therapist to his analyst', in H. Searles (1979) *Collected Papers on Countertransference and Related Subjects*. New York: International Universities Press.

Sedgwick, D. (1994) *The Wounded Healer: Countertransference from a Jungian Perspective*. London and New York: Routledge.

Solomon, H. (2000) 'The ethical self', in E. Christopher and H. Solomon (eds) *Jungian Thought in the Modern World*. London: Free Association.

Strachey, J. (1934) 'The nature of the therapeutic action of psychoanalysis', *International Journal of Psycho-Analysis*, 15: 127–159.

Symington, N. (1986) *The Analytic Experience: Lectures from the Tavistock*. London: Free Association.

Totton, N. (2000) *Psychotherapy and Politics*. London: Sage.

Ulanov, A. (1995) 'Spiritual aspects of clinical work', in M. Stein (ed.) *Jungian Analysis*. La Salle, IL: Open Court.

Williams, M. (1963) 'The indivisibility of the personal and collective unconscious', in M. Fordham with others (eds) (1973) *Analytical Psychology: A Modern Science*. London: Heinemann.

Winnicott, D. (1967) 'Mirror role of mother and family in child development', in D. Winnicott (1971) *Playing and Reality*. London: Tavistock.

Young-Eisendrath, P. and Dawson, T. (eds) (1997) *The Cambridge Companion to Jung*. Cambridge: Cambridge University Press.