Société Roumaine de Psychanalyse
Romanian Psychoanalytical Society

# REVUE ROUMAINE DE PSYCHANALYSE

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R*enaissance*

Société Roumaine de Psychanalyse

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**Thème:**

# Countertransference

## Le Contre-transfert

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# EDITORIAL

*Gianina Micu*[1]

Ce nouveau numéro de la Revue Roumaine de Psychanalyse accueille dans ses pages une série d'ouvrages intéressants sinon significatifs par leur approche variée d'un sujet qui anime plusieurs études et rapports cliniques et scientifiques de la psychanalyse actuelle. De grandes personnalités du monde de la psychanalyse signent la contribution au sujet, donnant de la valeur à la publication qui est arrivée à son cinquième année de publication, avec une fréquence biannuelle et une reconnaissance internationale de son professionnalisme. Comme preuve, la zone d'adressage de la revue augmente toujours (actuellement elle est disponible en plusieurs pays reconnus pour leur tradition dans la psychanalyse – la France, la Grande Bretagne, l'Italie, l'Allemagne, la Hollande, la Moldavie, l'Australie), elle est présente aussi dans les bases données internationales (EBSCO, Urlich, Eric etc.) – et ce processus est en cours. Si la valeur du Comité Scientifique et de *Peer Review* s'ajoute au contenu scientifique de la revue, l'application, l'enthousiasme et l'engagement des membres du Comité de Rédaction en assurent le reste d'ingrédients qui complètent, nous l'espérons bien, la recette d'une parution éditoriale importante du domaine.

Cette fois-ci encore, le sujet choisi se veut un sujet d'intérêt tant pour la théorie que pour la clinique psychanalytique. La relation thérapeutique considérée comme le pivot de la cure réclame son intérêt pour la pratique et la compréhension de chaque analyste. Si Freud considérait le Transfert la clé de voûte de la cure analytique, la relation inconsciente analyste-analysant a gagné depuis longtemps l'acceptation de la bidirectionnalité, que ce qui se passe parallèlement avec l'alliance thérapeutique, dans l'échange souterrain relationnel, dans le registre crypté de l'inconscient, apparaît subtilement dans les mouvements transférentiels précoces du patient et dans la réponse contre-transférentielle du thérapeute.

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Par conséquent, essayant à parcourir de manière restreinte la notion de contre-transfert, je commencerai par dire qu'elle est entrée, d'une certaine façon, dans la pensée psychanalytique par la «porte de derrière» parce qu'au début, elle était considérée un obstacle dans le processus de guérison, un obstacle que le psychanalyste y aurait introduit.

Dans l'œuvre de Freud le concept de contre-transfert, nous pouvons dire, a la même évolution que celui du transfert. Au début il est vu comme un obstacle, puis il est considérer comme outil très importante et difficilement évitable pour l'analyste. Dans un premier temps Freud recommande l'abstinence totale et l'évitement de contre-transfert de la part de l'analyste. En 1909, dans une lettre [1] à Jung, Freud utilise pour la première fois le concept de contre-transfert. Une année plus tard, Freud présente le contre-transfert comme un piège dans la cure et l'analyste doit l'éviter. Le contre-transfert « … doit être complètement surmonté par le médecin ; cela seul le rend maître de la situation psychanalytique ; cela fait de lui l'objet parfaitement froid que l'autre personne doit courtiser avec amour» [2]. Le contre-transfert, selon Freud, résulte de « … influence du patient sur la sensibilité inconsciente du médecin» [3], Pour éviter cette influence et pour pouvoir continuer l'analyse, l'analyste a besoin que son analyse personnelle soit continuée avec l'auto-analyse. L'analyse de son propre inconsciente est la condition impérative pour chaque analyste. Freud, même s'il considère que l'analyste faut s'abstenir de toutes réactions affectives face au patient, il était très conscient de l'importance du contre-transfert. Ainsi, dans une autre lettre qui datte de 1911, adressée à Jung, Freud il exprime son insatisfaction de son essai auquel il travaillait, *La dynamique du transfert*, et en ce qui concerne le contre-transfert, il recommande pour les analystes une attitude froid qui peut les protégés de transfert des névrosés. Dans cette lettre il écrit : « L'essai… sur le "contre-transfert", qui me semble nécessaire, ne devrait être imprimé, mais circuler parmi nous en copies» [4].

Son attention continue se focaliser sur le problème de contre-transfert et en 1913, dans sa correspondance avec Binswanger il écrit : « Le problème du contre-transfert (…) est un des plus difficiles de la technique psychanalytique. Théoriquement il est, je pense, plus facile à résoudre. Ce qu'on donne au patient ne doit jamais être un affect spontané, mais doit

toujours être consciemment exprimé, en plus ou moins grande quantité selon les besoins. Dans certaines circonstances, il faut donner beaucoup, mais riens qui soit issu directement de l'inconscient de l'analyste. (…) Donner trop peu à quelqu'un parce qu'on l'aime trop, c'est faire du tort au malade et c'est une faute technique» [5].

Les recherches ultérieures, surtout celles des psychanalystes adeptes de la théorie de la relation comme objet, parmi lesquels on mentionne M. Klein, D. Winnicott, P. Heimann, M. Little, Reich, Gitelson etc., ont élargi les aspects du concept de contretransfert et on compte de nos jours des acceptions telles les réponses affectives du psychanalyste à la présence du patient qui sont de plus en plus importantes pour la technique psychanalytique. Bien que chaque théoricien important de la technique et de la pratique psychanalytique d'après Freud ait contribué, d'une manière ou d'autre, à l'élargissement de la signification accordée au sujet, le plus important ouvrage qui a marqué la modification de la perspective d'approche relative au contretransfert et à sa valorisation dans le processus de guérison est celui paru en 1950 et écrit par Paula Heimann où on l'appelle pour la première fois „instrument psychanalytique principal" [6]. Si pour les kleiniens le contretransfert garde quand même aujourd'hui une nuance de pathologie, quoi qu'il s'affirme comme une source potentielle d'informations importantes sur la nature même de cette pathologie, car il met en discussion l'existence d'un espace de vie entre les deux – analyste et patient, pour les adeptes de la théorie de l'intersubjectivité, par exemple, le contretransfert semble ouvrir de nouvelles perspectives pour la compréhension clinique et l'espace psychique apparu dans la relation thérapeutique est considéré un „lieu" nouveau, différent de chacun, viable *entre* le patient et le thérapeute, lieu de réflexion et de création d'un monde partagé en commun [7].

L'élargissement de la notion de contretransfert jusqu'à l'inclusion de tous les mouvements affectifs de l'analyste dans la relation thérapeutique avec le patient, englobe généreusement (et difficile à la fois) une gamme très variée de concepts (du point de vue théorique) et d'affects (du point de vue de la clinique vécue), dont la division et la reconnaissance peuvent être envisagées comme une condition *sine qua non* pour la réussite de la cure. De la sorte, combien de mouvements contre-transférentiels sont des

*identifications projectives* de l'analyste (des analystes tels Weiss, Sandler etc. Considèrent l'identification projective comme élément significatif du contretransfert), comment sont-ils des sentiments de *sympathie et d'empathie* du thérapeute face aux sentiments de sont patient (McDougall, Kohut) et surtout, j'en soulignerais, combien sont-ils des *interférences transférentielles de l'analyste* vers l'analysant (tel que des analystes kleiniens les considèrent parfois) – tout cela constitue des aspects qui, à partir de l'acceptation de la réalité du fait qu'on ne peut pas les éviter, donnent l'image de la difficulté du travail que l'analyste doit faire afin de comprendre le patient, se comprenant tout d'abord lui-même en rapport avec celui-ci.

Bref, le contre-transfert représente une des dimensions très importantes du processus analytique et implique directement le psychisme du thérapeute. C'est le versant de la relation thérapeutique qui englobe les réactions conscientes et inconscientes du thérapeute face au transfert du patient. Nous pouvons dire que le contre-transfert rend compte de la force et de l'influence du psychisme du patient sur le psychisme du thérapeute. Le contre-transfert représente la manière de l'analyste de faire face aux projections et aux déplacements surtout inconscients, opérées par le patient dans le cadre de la cure.

Plusieurs spécialistes aborderont sous divers angles le contre-transfert, ce qui nous offre un éclairage sur ce concept, mettant au centre de l'attention l'inconscient de l'analyste par les réactions qu'il manifeste dans le cadre de la cure en relation avec le psychisme du patient.

Le contre-transfert détient à côté de transfert un rôle clé dans la cure analytique.

L'analyse du contre-transfert maintient ouvert le processus analytique sans qu'il soit un instrument thérapeutique. La plus importante pour le processus analytique est la capacité de l'analyste de contenir les émotions, les angoisses du patient. La valeur du contre-transfert pour le processus analytique est donnée par la subjectivité de l'analyste. La relation analytique dépend d'un côté, de la capacité de l'analyste de faire place dans son psychisme au patient, de le contenir et de l'autre côté, dépend de la signification que l'analyste a pour son patient, le sens que le patient lui attribue. Ainsi l'analyse du contre-transfert a un rôle modéré et contrôlé dans le processus analytique.

Le contre-transfert n'est pas réduit seulement à ce que l'analyste exprime verbalement ou corporellement d'une manière visible. L'analyse des interactions transfert-contre-transférentielles nous aide à comprendre la complexité de la relation thérapeutique, le sens du silence dans cette relation, la signification du non-dit et de l'inaudible. La dimension archaïque de la relation analytique, d'où surgis les contenus inconscients du patient qui sont déplacés, transférés sur l'analyste, est aussi rendue accessible par l'analyse de cette interaction transfert-contre transférentielle.

La relation analytique qui implique tant le transfert que le contre-transfert, n'est pas une relation qui s'installe dans n'importe quelles conditions. Le contexte dans lequel les interactions transfert-contre-transférentielles s'y installent et s'y développent, représentent le cadre analytique. Entre le cadre analytique et l'interaction transfert-contre-transférentielle il existe une influence réciproque.

Le cadre doit être protégé par l'analyste contre les attaques venues de l'intérieur et de l'extérieur et à son tour le cadre va protéger les deux protagonistes de l'acte analytique.

Mais le contre-transfert doit être bien maîtrisé par le thérapeute et la capacité, l'habilité de l'analyste à maîtriser son contre-transfert n'est pas la même tout au long de sa pratique. L'expérience de l'analyste influence aussi la capacité de maniement du contre-transfert. Aussi importante que l'expérience de l'analyste est sa personnalité, le mélange de la personnalité et de l'expérience clinique chez l'analyste donnent la particularité du contre-transfert de chaque analyste et assurent la maitrise de celui-ci (contre-transfert).

Dans le cadre de la cure est-il bien ou pas de nous laisser sentir et agir en fonction du psychisme de nos patients? Est-il bien avoir des réactions aux contenus psychique inconscient ou faut-il nous abstenir de n'import quel écho qui puisse se produire en nous en fonction du rôle ou de la signification que nous attribue le patient?

L'analyste, dans sa pratique clinique, doit se soumettre à certaines règles qui visent l'échange affectif avec le patient. Une de ces règles vise l'abstinence de l'analyste dans son rapport au patient ce qui touche aussi le contre-transfert. Dans la relation analytique s'établie un certain rapport entre l'abstinence et le contre-transfert. Ce rapport se déroule en trois

moments qui sont décrits dans cette présentation. La relation entre l'abstinence et le contre-transfert vise le principe de la «gratification optimale». La solution, à laquelle sont arrivés certains analystes, dans leur expérience clinique pour éviter des points de vue unilatéraux sur le processus analytique, est «le principe de la facilitation optimale de l'analyse».

Dans notre époque où la valeur d'une science est donnée par ses concepts qui se prêtent à l'évaluation quantitative, la psychanalyse ne peut pas rester indifférente. Ainsi, dans le champ de la psychanalyse, les chercheurs ayant une grande expérience clinique dans la psychanalyse, mettent en discussion l'évaluation du contre-transfert et la méthodologie par laquelle cette évaluation est possible. La méthodologie de recherche proposée par les deux psychanalystes-chercheurs n'affecte pas la spécificité du processus analytique et ne modifie pas le cadre de la cure.

Les diverses points de vue des chercheurs ainsi que chaque perspective qu'ils ont proposée relative à la place et à l'importance du contre-transfert dans la théorie et la pratique apportent une contribution remarquable sur la connaissance de ce sujet.

A la fin de ce numéro, on trouvera, comme d'habitude, la rubrique dédiée aux comptes-rendus des livres. Cette fois-ci nous avons remarqué l'ouvrage classique *L'écorce et le noyau* conçu par deux grands psychanalystes, Nicolas Abraham et Maria Torok. Sa présentation est claire et concise et même si ce n'est qu'une introduction à l'ouvrage, elle rend le lecteur curieux à lire le texte intégral.

Pour conclure, je voudrais rappeler, en tant qu'appui et argument de l'importance accordée à cette problématique, le fait que le concept de *contre-transfert* a été aussi le sujet de la Conférence de Psychanalyse que la Société Roumaine de Psychanalyse avait organisée à Bucarest en octobre 2011. Cette manifestation scientifique a aussi voulu signifier le début de l'affirmation de notre ouverture, comme Société de Psychanalyse qui est récemment devenue Société Provisoire IPA, vers l'échange d'expérience professionnelle avec d'autres écoles et courants de pensées psychanalytiques. Encouragés par les feed-back qu'on a reçus à cette occasion, le sujet du Contretransfert est devenu le thème central du numéro actuel ainsi que du numéro prochain de notre revue.

**REFERENCES**

1. FREUD, S. (1906-1909) *Sigmund Freud-C.G. Jung : Correspondance,* vol.1, Paris, Edition Gallimard, 1975, trad. R. Fivaz-Silbermann.
2. FREUD, S. (du 07. 10. 1908 au 15. 06. 1910) dans *Les premiers psychanalystes, Minutes (II) de la Société Psychanalytique de Vienne,* Paris, Edition Gallimard, 1978, trad. N. Bakman.
3. FREUD, S. (1910), « Les chances d'avenir de la thérapeutique analytique » dans *La technique psychanalytique*, Paris, Edition PUF, 1972, trad. A. Berman.
4. FREUD, S. (1906-1909) *Sigmund Freud-C.G. Jung : Correspondence,* vol. 1, Paris, Edition Gallimard, 1975, trad. R. Fivaz-Silbermann.
5. FREUD, S. (1908) *Sigmund Freud-Ludwig Binswanger: Correspondence 1908-1938,* Paris, Edition Calmann-Lévy, 1995, trad. R. Menahem et M. Strauss.
6. HEIMANN, P. (1950) – On countertransference, *Int. J.Psychanal*. 31:81-84.
7. HINSHELWOOD, R. D. – Countertransference, *Int. J. Psychoanal*., 1999, 80, 797.

# Psychanalyse théorique et clinique

# Clinical and theoretical psychoanalysis

# IN FAVOUR OF A MODERATE USE OF COUNTERTRANSFERECE: THE HISTORY AND THE PRESENT SITUATION

*Franco de Masi*[2]

**Résumé**

*Le contretransfert est un de plus importants instruments de la démarche analytique. Dans cet article, j'essayerai de mettre en évidence les différentes manières dont on a pris en considération le transfert selon l'importance de la subjectivité de l'analyste. Un aspect important fait référence à la valeur thérapeutique de l'élaboration du contretransfert. Mon hypothèse consiste dans le fait que ce processus nécessaire n'est as suffisant pour assurer le progrès thérapeutique. Je crois que l'analyse du contretransfert est essentielle pour garder ouvert le processus analytique, mais elle ne représente pas un instrument analytique en soi. De manière constante, l'analyste devrait être impatient à intégrer le monde du patient avec chacun de ses éléments (souvenirs, reconstructions, appréciations sur les expériences de vie, y compris les expériences personnelles), processus utile pour le développement de la vie émotionnelle du patient.*

*La relation analytique dépend de la*

**Abstract**

*Countertransference is one of the most important tools of the analytic work. In this paper, I will try to show how countertransference has been considered in different ways according to the importance paid to the analyst's subjectivity. One important problem concerns the therapeutic value of the elaboration of countertransference. My hypothesis is that this necessary process is not enough to promote the therapeutic progress. I think that the analysis of countertransference is essential in order to keep the analytic process open but it is not a true therapeutic tool per se. The analyst should constantly and eagerly integrate the patient's world with every element (memories, reconstructions, considerations on life experiences, including his own) that can be useful in widening the patient's emotional life.*

*The analytic relationship depends on the analyst's capacity to create and maintain in his mind a place for the patient (for his history, his difficulties and his tacit*

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*capacité de l'analyste de créer et de garder dans son esprit une place pour le patient (pour l'histoire de sa vie, pour ses difficultés et pour sa sollicitation tacite de développement mental et émotionnel) et pour la disposition du patient de considérer l'analyste comme un objet transformateur indispensable pour son développement. Le processus analytique continue et progresse à condition que cette relation reste vive. De cette perspective, l'analyse du contretransfert joue un rôle modéré et autocontrôlé.*

*request for mental and emotive development) and on the patient's disposition to consider the analyst as a transformative object that is indispensable for his growth. The analytic process continues and progresses as long as this relationship remains alive.*
*In this perspective, the analysis of countertransference plays a moderate and self-controlled role.*

**Mots-clés:** transfert, contre-transfert, identification projective, rêverie, transformateur.

**Key words:** transference, countertransference, projective identification, reverie, transformative

It is well known that countertransference is one of the most important tools of the analytic work. The continuous focus on our feelings in the session proves important at least from two points of view.

In a positive way our countertransference highlights the non verbal contents of the patient's communication; in a negative way it can show that our emotions can interfere with the careful listening to the patient and give rise to an analytic impasse.

In this paper I will try to show how countertransference has been considered in different ways according to the importance paid to the analyst's subjectivity.

We can distinguish two trends in the clinical use of countertransference. The first one asks for a limited use of countertransference and considers the analyst's emotive feelings useful mainly for understanding what the patient communicates without words.

The second trend, making a larger use of countertransference, is divided into two groups. The first is led by Betty Joseph who considers transference as the total situation and maintains that the patient's whole communication refers to the analyst who runs the risk of being captured by

the patient's defences unless he interprets the material through his own countertransference.

The second group (Ogden) broadens the concept of rêverie and affirms that the analyst's subjective fantasies and dream-like associations are a special route for interpretation. The feelings experienced by the analyst and the thoughts, daydreams and fantasies that may arise in his mind, apparently not associated with the session, are the evocative level of countertrasference.

Freud advised an emotive neutrality to the analyst because he considered psychoanalysis as a scientific discipline very far from any personal influence. Accordingly, he considered countertransference a problem derived from the analyst's incomplete analysis. It is interesting to note that Freud used the word "countertransference" for the first time in a letter to Jung, commenting on the erotic involvement of the latter with his patient Sabina Spielrein. Furthermore, he destroyed his metapsychological paper on countertransference, because he considered this subject to be very dangerous for the public image of psychoanalysis.

It is worthy noting that Freud himself did not follow his very advice, as Luciana Nissim Momigliano (1987) [10] writes in a lively and intelligent paper *"A spell in Vienna: but was Freud a Freudian?"*. Freud used to have conversations with his patients and give advice to them; sometimes, he openly disliked some of them while inviting others to dinner.

The first analyst who stressed the importance of countertransference was Ferenczi (1919) [4] who believed that the analyst could learn much about himself from the patient and, at the same time, the patient could benefit from understanding how the analyst's personality and conflicts may affect his thought processes.

Stern (1924) [16] was the first who distinguished two forms of countertransference: one stemming from the analyst's personal conflict and the other arising in response to the patient's transference. The former constitutes an obstacle to understanding. Stern believed that the analyst must tune his own unconscious with that of the patient in order to grasp the latter's unconscious communications.

The analyst's emotions towards his patient became an important and stimulating topic only after the publication of Paula Heimann's paper on the countertransference (1950).[3]

Paula Heimann's paper turned upside down the Freudian myth of analytic neutrality. In her words: *"the analyst's emotional response to his patient within the analytic situation represents one of the most important tools for his work. The analyst's countertransference is an instrument of research into the patient's unconscious"* [6].

Thus, the analyst's emotional participation becomes one of the main tools of the analytic therapy. In other words, the analyst reacts emotionally to a patient's creation (the transference) that is also a part of his personality.

We know that Melanie Klein disliked Heimann's paper. It was one of the reasons, perhaps, for their separation after many years of close collaboration.

Klein's view on countertransference is close to Freud's. She considered it an unwelcome emotional response to the patient where the analyst is too overwhelmed, or too antagonistic to the patient. The analyst's stability, she thought, should protect him from countertransference.

In a seminar held in 1958 she said: *"I have never found that countertransference has helped me to understand my patient better. If I may put it like this, I have found that it helped me to understand myself better."* [15]. She added: *"Where countertransference is unavoidable, it should be controlled, studied and used by the analyst for his own benefit, I would say, and not for the benefit of the patient, I don't believe in it."* [15].

**The unconscious roots of countertransference**

In every analysis, beside the conscious meaning carried by words, an unconscious emotive communication is at work.

Freud (1915) [5] described this kind of unconscious communication when he spoke about the analyst's unconscious as a receptive organ that registers the patient's unconscious.

[3] According to PEP Archive CD-ROM only 90 articles referred to countertransference prior to 1950 (1,6 % of all articles), whereas from 1950 onwards there were 3.685 such articles (16,5 % of all articles). (Hinshelwood, 2002).) [7].

Money-Kyrle (1956) [11] and later Bion (1959) [1] thought the analyst behaves like the container of the patient's experiences, the same way that an infant cries, performing a kind of projective communication in which his distress is actually introjected and felt by its mother. This kind of introjection performed by the analyst is his countertransference.

This new point of view originates from a progressive shift of the meaning of projective identification performed by post-kleinian authors, in particular by Bion. In Melanie Klein's conception, the projective identification is a psychotic mechanism through which the patient projects parts of the self into the object. Consequently, he feels confused, intruded and persecuted by the same object into which the projection has happened. In the post-kleinian elaboration of the concept, the emphasis has shifted from the patient projecting to the object receiving the projection. This way, the projective identification becomes a relational event in which the receiver can understand what has been communicated by projection and without words.

In describing the phenomenology of countertransference performed by the projective identification, Bion (1952) [1] says the analyst feels manipulated and pushed to represent the role of another person. It is not the matter of an unconscious phantasy but of an interpersonal event.

**Variability**

As I said before, there are different kinds of conceptualizing countertransference in the psychoanalytic thought.

Among the authors that consider it of minor significance, except when it corresponds to a pathological disturbance of the analyst, there is Anne Reich (1951) [1] who, in the United States, took a position similar to Freud's and Klein's and influenced the analysts of her country. Admitting that countertransference is not only inevitable in analysis but it is also a necessary ingredient if the analysis is to be emotionally engaged, she reiterated Freud's view that it must be mastered. She says that countertransference is not the royal road to the unconscious; it rather represents the arousal of conflicts in the analyst that have the effect of interfering with his ability to respond to the patient's communication.

The influence of this point of view in America, as pointed by Jacobs (1999) [8], was enormous and for some years a curtain of silence descended on the topic in America.

From a different cultural field, Racker (1988) [13] opened up many previously unexplored dimensions of countertransference. For example, he distinguishes between direct and indirect countertransference reactions. Direct reactions are those which are stimulated by the patient, indirect reactions arise from the environment, from teachers, supervisors, colleagues or other significant individuals who exert an influence on the analyst. In other situations, the analyst may be influenced by his own reactions to individuals in the patient's world. A male analyst, for instance, may develop feelings of rivalry toward the partner of a female patient as a reactivation of his oedipal conflict. In Racker's study, his interest is focused predominantly on countertransference as a technical instrument, that is, as an essential means in understanding the psychological processes (and especially the transference processes) of the patient. The role of the countertransference in the process of the patient's internal transformation is studied, that is to say, the influence of countertransference in the destiny of transference.

Racker's innovative study stimulated an interest in countertransference as a phenomenon whose effect on the analytic process is clearly profound.

Another important contribution on this subject comes from Money-Kyrle's paper (1956) [11], *Normal Countertransference and its deviations.*

Money-Kyrle underlines that when the patient speaks, the analyst will become introjectively identified with him and, having understood him inside, will reproject him and interpret.

When this understanding fails, as it happens from time to time, the analyst becomes, consciously or unconsciously, anxious. The anxiety still furthers to diminish understanding and this is the onset of a kind of vicious spiral that constitutes every deviation in normal countertransference feeling.

Money-Kyrle says that the extent to which an analyst is emotionally disturbed by periods of non-understanding will depend on the severity of his own superego. If this superego is predominantly friendly and helpful, the analyst can tolerate his own limitations without undue distress and will

be more likely soon to regain contact with the patient. But if it is severe, the analyst may feel a sense of failure or a persecutory or depressive guilt. Or, as a defence against such feelings, the analyst may blame the patient.

Money-Kyrle's work shows how the indigested projections from the analyst are reprojected onto the patient and can result in an impasse in the analytic process. Only the analyst's analysis of his countertransference may re-establish the necessary conditions for the resumption of the therapeutic work.

**Countertransference as a predominant element**

It is especially in the post-Kleinian group that countertransference becomes the specific and revealing tool of the analytic technique. In this view the whole analytic work goes through an on-going elaboration of the dynamics of transference and countertransference.

In his paper "*Transference: The Total Situation"* (1985) Betty Joseph develops the idea of transference as a framework, in which something is always going on, where there is always movement and activity*: "Much of our understanding of transference comes through our understanding of how our patients act on us to feel things for many varied reasons; how they try to draw us into their defensive systems; how they unconsciously act out with us in the transference, trying to get us to act out with them..."* [9].

According to Betty Joseph, the patient and the analyst are involved in a total relationship where there is no place for any other concern, such as the reconstruction of the patient's history.

She asks herself whether it is useful to interpret transference and countertransference in order to reconstruct the past related to them.

She feels that it is better not to make these links because they can disrupt what is going on between the analyst and the patient during the session. Joseph prefers to wait until the patient has sufficient contact with himself and is able to make such links. Her opinion is that even the reconstruction of the past can be used in a defensive way against the emotions towards the analyst.

**The countertransference as reverie**

A group of contemporary analysts (like Ogden and Ferro) maintains that the reverie, which corresponds to the analyst's subjectivity and imagination, can be turned, after a suitable working through, into something meaningful to say to the patient.

In their view, the analytic process generates new intersubjective experiences that had never happened before in the affective life of either patient or analyst. Accordingly, Ogden (1994) [12] uses the term countertransference and clarifies that it is not a separate entity originating in response to transference, but it is rather an aspect of the intersubjective unity generated inside the analytic couple (*the analytic third*) and experienced individually by patient and analyst. Conflicts, dynamics, and even the patient's past are created in a specific way by the couple.

From this point of view, since the patient is unable to "dream" his own history and life, his analytic communication helps the analyst in "dreaming" him.

*"Analysis is seen as dreaming the patient's interrupted and undreamt dreams"* [3]; *" In analysis, any reverie likewise permits contact with the sequences of alfa-elements synthesized by alfa-functions and anything that is recounted is ( in virtual terms) always at the same time a narrative derivative of waking dream thought."* (pag. 279)

Here, the patient's history, which in Joseph's view was already irrelevant, loses its value. The boundary between the patient and the mental life of the analyst becomes rather vague and indistinct. The same happens with the patient's psychopathology, the rules of the mental development, the relations between the conscious and the unconscious, the repression, in other words with some important elements of the clinical work.

**Discussion**

As an analyst supervisor, I often find students oddly frightened when they have to face the examination for the associate membership. Most

students write a good account of the psychoanalytical process, describing the patient's childhood and his/her emotive trauma, interpreting transference as repetition of the first relationships, exploring and describing the internal world of the patient and the dynamics between the sane and the pathological part, but they are afraid to emphasize too much trasference-countertransference dynamics.

These students' point of view seems to derive from their teacher's opinion that analysis is different from psychotherapy due to its interpretation of the dynamics of transference-countertransference.

This theory of technique maintains that all positive transformations depend on the dynamics of the two.

Willing to conform to this learning, students are sometimes led to interpret most of the patient's communications as containing transference meaning. Students can also interpret as transference what it is not. There is a risk to leave out other meaningful experiences of the analytic process.

As an example of my point, I will bring a clinical material discussed with a colleague in supervision.

*The patient, a young lawyer, is 30 years old when he starts his analysis. His most intimate relationship had been with his mother, who always protected him. One of his most powerful recollections was of her coming into his bed after lights-out, feeding him with candies. Even now he has difficulty going to sleep without devouring sweets. Toward the end of his adolescence his mother was diagnosed with chronic depression.*

*Around the age of 20, he discovered his seductive powers. He used to seduce a different woman every night, sometimes men as well and he obtained great gratification from the excitement and from the fast turnover. He compulsively masturbates in front of the computer, usually visiting pornographic sites.*

*In the first months of the analysis that analyst was feeling that the patients talks but was actually staging for the analyst's sake. In the course of one session, he reported a dream: "I enter a room and you're asleep. I wake you. You're lying on another couch, in the other room, and when I wake you, you say - ' I dreamt that I slept with you.' I lie down beside you but don't sleep with you."*

*The analyst said to the patient that through this dream he was actually telling him that what they had there was a kind of "double couch". There was the*

*couch on which he was being "in analysis", and there was another couch, in another room, on which there was an entirely different conversation going on. In the dream there was a wish to "wake the analyst up", or maybe to arouse something in him. But when he "goes to bed with the analyst"(lies down beside him), he actually puts the wish with the analyst: it is the latter who say: "I dreamt that I slept with you."*

*The analyst started to wonder about how this confusion was enacted between him and the patient. And indeed, a sense of exhaustion and boredom started permeating the analysis, an unbearable heaviness. In one session the patient remembered that when he was about eight he found a video cassette of his mother. It was a pornographic cassette. He took and hid it from her; afterwards, he did not return it. He was sure that she knew who took it, but she never spoke a word about it. At a later stage he told the analyst that his fantasy was that she and he used to masturbate with the same scenes.*

*The analyst interpreted very often that the patient's relation with him was not the rules of relationships involving two subjects. In this sense there was nothing the patient wanted more than turning the analyst into this "thing" that he manipulated, but at the same time there was nothing he feared worse.*

*In a session the patient told the analyst a dream. In the dream he found himself in a hidden valley. There was a horse race going on but the horses ran without reins and there was no track. Suddenly, he noticed a figure becoming distinct and approaching him. It took him a while to realize it was a pig. He did not understand what the pig was doing there, but the pig was looking at him, and its expression was so wise and sad that the patient, too, could not take his eyes off it.*

*When the analyst asked him about this dream he said: "the pig is a reflection of myself". The analyst said: "It is the swine-like part of you that is looking at you." In the analyst's view making the perverse pact between them explicit indeed brought out the patient's swine-like part in the course of the following months. No more seductions, no more whispered spells.*

*He no longer covered up or hid anything from the analyst. The analyst thinks that this new period of analysis represents a progress. In fact, at times, he addresses the analyst as the basest slave or as a whore. During one session he said: "Do your job, sweetie, I'm paying for you to work".*

My impression is that the last phase is not a progress but, instead, a proof that the perverse part of the patient is now triumphant, perversely distorting the analytic relationship and transforming the analyst into a masochistic partner.

The patient, who had a special and erotized relationship with his mother, is a sexualized man masturbating himself continuously.

In my opinion, the sexualized world is projected continuously into the analyst who is transformed in the pathological self of the patient. As a result, there is confusion between the patient and the analyst and between which part belongs to each.

I think that the analyst has worked mostly through transference-countertransference interpretations (here and now) without any attempt to reconstruct the pathological relationship with his mother that appeared again and again in transference. In the patient's view, both of them, he and his mother (he and the analyst), can masturbate themselves with the same pornographic picture.

Intrapsychic interpretations (those that can show to the patient the struggle between the sane and the pathological part and the attempt of the latter to colonize the sane part) are lacking. As a result, the patient tries to colonize the analyst's mind with the same propaganda that colonizes his own mind.

In my opinion, in the therapy of perversion it is important to analyze the patient's inner world in order to help him to differentiate between the sane and the pathological sexualized part and to sort out the power of the latter.

It seems to me that, in this case, the power of the perverse part has not been reduced during the analytic treatment because the analyst had worked mainly at transference-countertransference level.

This is very clear in the dream in which there are some horses without reins and without track. In my view, the patient is describing his perception of being like a wild horse without any containment from the analyst, while he is hypnotized and persecuted by a pig, the dirty and sexualized part of himself.

In my opinion, the therapy is heading to an impasse because the analyst has worked mainly with trasference-countertransference interpretations.

I suggested to the colleague that he should take into consideration in a systematic way the patient's internal world, his infantile sexualized retreat, and, above all, his submission to a perverse pathological internal structure.

**The present situation**

Nowadays, all analysts consider countertransference as a necessary tool to pick up the patient's communications, conscious and unconscious, verbal or silent. We also know that the analyst's emotive and empathic participation in the session is fundamental for the patient's progress.

Usually, the patient is very attentive to the way we listen to his communications: how we react to his silence, whether we share his sufferings or his joys and so on.

This active emotive participation of the analyst helps build what I call the *analytic relationship*.

A great part of the therapeutic process depends precisely on the ability of the patient and the analyst to create a relationship useful for the emotive development.

I distinguish transference and countertransference from the *analytic relation*. We could say that while transference originates from the patient's projections, from his split parts, or from his infantile wishes, the analytic relationship stems from the meeting of the analysand's and the analyst's receptive parts and develops with the contribution of both. If the analytic relationship relies on the wish to mutually communicate, the patient's psychic development depends on the interpretative capacity of the analyst, that is from his receptivity and from the fittingness of his emotive response to the patient's communication.

For this reason it is important to modulate our countertransference.

The process of modulating our responses is often not easy. For a long time the analyst has had the difficult task of being only the receptor of the patient's projections. He must understand and bear them as an essential part of his therapeutic work and he cannot always formulate his thoughts in an open way because he must consider, moment by moment, to what extent the patient is able to recognize the truth.

**What role for the analyst?**

If we consider the patient's psychopathology and history from the beginning, it is possible to foretell what kind of countertransference will arise in the analyst.

For instance, a narcissistic patient will give his analyst feelings of inferiority and envy: the patient knows everything, is always happy, owns all the good in the world ...

We can also foretell the role assigned to the analyst by a melancholic patient. Here the analyst's devalued feelings originate from the continuous propaganda of the patient about the uselessness of analysis and analyst. We know how the melancholic patient torments himself and the object and how he can find a paradoxical relief by taking away from himself all the pleasure and from the analyst his therapeutic satisfaction.

The patient's projections are not always negative. The patient is often seeking a privileged relationship and tickles the analyst's narcissism. The analyst has to resist the patient's seduction, as in the erotic transference. However, he should tell true from false through a good use of his countertransference.

**The clinical value of countertransference**

If we cannot imagine an analysis without countertransference, what the actual value of the countertransference is, what does it really tell us about the patient?

My point of view is different from those (among them Betty Joseph, 1985) [9] who think childhood may be reconstructed only when the analysis has made substantial progress through the elaboration of transference and countertransference.

My opinion is that important parts of the patient's past and his relationship with parents can be obtained from the patient's memories at the beginning of the analysis. In many cases, the reconstructive interpretations must be considered very important and it is necessary to communicate them to the patient every time they appear meaningful. At the beginning of every new analysis, I am attentively listening to the

patient's story, confronting his conscious memory with his current difficulties. From the difference between his conscious account and his present suffering, I can hypothesize something important about his emotive history, his infantile traumata and his distorted development.

When treating traumatized patients, the analyst should participate and elucidate the past events with all their emotive consequences and connections. However, the reconstruction of the past cannot be limited to turning repressed memories into consciousness. What is striking in many cases is not the quality of the trauma, but the lack of any human environment liable to contain and maybe transform its violence. It is essential for the patient to live the past over again in the presence of a new object. The analyst is bound to become the object lacking in past traumatic experiences.

This element is essential for the transformation to happen.

When the patient is unable to talk about his history, the experience of emotive trauma often manifests itself in transference.

*I understood very little in the first interview of a woman, thirty years old. She was silent, without any facial expressions. Perhaps she wanted to inquire my personality instead of communicating something from her life. The analysis began with only two sessions a week for problems of time and money, with the pledge of increasing them as soon as possible. We did not talk about this problem anymore. After the first holidays, the patient abruptly accused me of having unilaterally decided to increase her sessions to three. In my countertransference, I felt rather puzzled and I almost thought she was talking about somebody else, not me. I imagined that perhaps she had confused me with her father about whom she had never spoken. From this moment on, an important part of her analysis concerned her relationship, internal and external, with her father, a tyrannical man who claimed the right to intrude in the patient's life without any concern for her needs. I understood that, for this reason, the patient had been subject, since her childhood She couldn't even rely on her mother either, because she was also dominated by her husband. After this episode, the analytic atmosphere improved a little.*

The analyst has to be a new object, different from the past, able to create the conditions for a new development and a new meaning.

Traumatic experiences, constantly re-enacted in transference might imply a lack of analytic function.

One last problem concerns the therapeutic value of the elaboration of countertransference. My hypothesis is that this necessary process is not enough to promote the therapeutic progress. I think that the analysis of countertransference is essential in order to keep the analytic process open but it is not a true therapeutic tool per se.

In my clinical work, I concentrate more on the exploration of the patient's inner world, on his traumatic history and, in particular, on the effect of infantile intrusive objects that have created pathological constructions. In my opinion, overemphasizing transference and countertransference dynamics narrows the open-mindedness of the analytic couple, hinders analytic freedom and results in a claustrophiliac relationship.

The analyst should constantly and eagerly integrate the patient's world with every element (memories, reconstructions, considerations on life experiences, including his own) that can be useful in widening the patient's emotional life.

The *analytic relationship* depends on the analyst's capacity to create and maintain in his mind a *place* for the patient (for his history, his difficulties and his tacit request for mental and emotive development) and on the patient's disposition to consider the analyst a *transformative object* that is indispensable for his growth. The analytic process continues and progresses as long as this relationship remains alive.

This intimate creative experience will allow the patient to learn from emotive reality and to find his personal meaning.

In this perspective, the analysis of countertransference plays a moderate and self-controlled role.

## REFERENCES

1. BION, W. (1955). Attacks on linking, *Int. J. Psycho-Anal.*, 40:308-315, republished in *Second Thoughts.* London: Heimann (1967).

2. BOLLAS, C. (1979). The Transformational Object, *Int. J. Psycho-Anal.*, 60, 97-107.
3. CIVITARESE, G. (2011). Exploring Core Concepts: Sexuality, Dreams and the Unconscious. Response by Giuseppe Civitarese. *Int. J. Psychoan.*, 92:277-280.
4. FERENCZI, S. (1919). On the Technique of Psychoanalysis. In *Further Contributions to the Theory and Technique of Psychoanalysis*. New York Basic Books, 1952, pp.198-217.
5. FREUD, S. (1915a). The Unconscious. *S.E.*, 14
6. HEIMANN, P. (1950). On Countertransference. *Int. J. Psycho-Anal.*, 31:81-84.
7. HINSHELWOOD, R.D. (2002). Countertransference. In *Key papers on Countertransference,* ed. by Michels R. et al., p. 41-79.
8. JACOBS, T.J. (1999). Countertransference. Past and Present: a Review of the concept. *Inter. J. Psycho-Anal.,* 80:575-594 .
9. JOSEPH, B. (1985). Transference: The Total Situation. *Int. J. Psycho-Anal.*, 66:447-454.
10. MOMIGLIANO, L.N. (1987). A Spell in Vienna - but was Freud a Freudian? *Int. J. Psycho-Anal.*, 14:373-389.
11. MONEY-KYRLE, R.E. (1956). Normal Counter-Transference and Some of its Deviations. *Int. J. Psycho-Anal.*, 37:360-366.
12. OGDEN, T.H. (1994). *Subjects of the Analysis.* Jason Aronson Inc. Northvale, New Jersey, London.
13. RACKER, H. (1988). Transference and countertransference. *The International Psycho-Analytical Library*, 73:1-196.
14. REICH, A. (1951). On countertransference. *Int. J. Psychoanal.*, 32:25-31
15. SPILLIUS, E. (2007). *Encounters with Melanie Klein Routledge.*
16. STERN, A. (1924). On the Countertransference in Psychoanalysis. *Psychoanal. Rev.*, 2:166-174.

# LA COMMUNICATION PRIMITIVE, LE SENS ET LE NON-SENS DU SILENCE DANS LES MOUVEMENTS CONTRE-TRANSFÉRENTIELLES

*Daniela Luca*[4]

- in memoriam Joyce McDougall -

*Motto:*

"Sur mon lourd chemin, j'ai contemplé des merveilleux pays, mais il m'a fallu me confronter aussi avec des êtres sinistres et des obstacles presque impassables, c'est pourquoi je me suis effondré des fois. (…) Je dis la vérité quand j'affirme que je ne connais pas d'autres régions, que mon ignorance concernant d'autres réalités est immense, mais que, en revanche, je peux revendiquer une recherche passionnante sur le chemin que j'ai toujours suivi. "

*(Ernesto Sabato)*

**Résumé**

*Le travail propose l'exploration – par l'intermédiaire des théories psychanalytiques et contemporaines – des nuances et des sens du silence, de la communication primitive, non-verbale, affective, archaïque, dans la cure analytique, surtout par le saisis et l'analyse des mouvements transféro-contre-transférentielles, et aussi le destin de*

**Abstract**

*The purpose of this paper is to explore – by means of contemporary psychoanalytical theories – the nuances and the sense of silence, of primitive, non-verbal, affective, archaic communication in the psychoanalytical work, with a special focus not only on distinguishing and analyzing the transference/countertransference movements but also on the destiny of the*

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*l'inaudible et du non-dit dans la création du sens psychique et des significations essentielles dans la relation analyste – analysant.*

*unheard and unsaid in creating psychic sense, as well as on the essential significance in the analyst-analysand relationship.*

**Mots-clés:** *communication primitive, état-limite, résonance de la souffrance, silence, sujet analytique, transfert – contretransfert archaïque.*

**Key words:** *primitive communication, borderline, the resonance of sufferance, silence, analysand, archaic transference-countertransference*

**Prologue ou silence en avant**

Joyce « avec mille et un visages » a rencontré, le 24 aout 2011, les visages infinis de la mort. Je suis entrée dans un lourd silence, c'était le jour avant l'Ecole d'Été de Psychanalyse – SRP. Je n'ai même pas pu *partager* avec mes collègues cette résonance affective de la perte. Je ne savais même pas s'ils avaient déjà appris sa mort, je n'osais rien demander. Le silence planait sur le mort de Joyce McDougall. Quelques semaines avant, la psychanalyse avait déjà perdu Hanna Segal, le 5 juillet 2011. C'était juste pendant l'École d'Eté de Psychanalyse de l'Enfant – Fondation Generatia, et c'était Luis de la Sierra qui nous avait partagé la nouvelle de sa mort.

La mort d'un grand psychanalyste, et surtout un grand homme, tellement généreux par la force et la capacité de transmettre le savoir, l'écriture, la culture, nous plonge dans un indicible réverbérant mais sombre, une sorte de pétrification de ceux temps psychiques où la signification de la perte a la dimension d'une carrefour-nœud, où « les mots pour le dire » restent seulement des véhicules inertes pour les sensations, vécus, sentiments, affects, émotions archaïques et primitives ; ils touchent ces expériences originaires de la naissance psychique, quand la vie et la mort se conjuguaient à l'identique, et leur coïncidence étant vécue dans un temps où « le Moi n'était pas encore là » pour les ressentir, les surprendre.

Ils m'ont fallu des jours, même des semaines, pour que je puisse transposer tout en pensées écrites, pour avoir des mots, pour travailler cet exposé psychanalytique que j'ose le transmettre à l'hommage de celle qui a

été et qui va toujours rester Joyce McDougall.

Je vais commencer cet exposée par quelques réflexions de Joyce McDougall [8] sur le sens des mots et les sens du silence dans l'analyse:

*« Il n'est pas mon propos de reprendre ici les concepts fondamentaux de Freud concernant les mots, leur soumission aux lois du fonctionnement de l'inconscient, et la nature de leur structuration qui rend sens aux symptômes névrotiques. C'est de l'affect, et des mots « affectés » et « dés-affectés » que je veux parler ici. L'économie spécifique de l'affect s'infiltre dans la langue à tout moment. Remarquons que sans cette imprégnation puissante aucun enfant n'aurait appris à parler ! Le fait d'être* obligé *de verbaliser ses désirs et besoins est une des blessures narcissiques de l'être humain. (…) En dépit du fait que la psychanalyse est une science centrée sur la signification, et que sa logique est la logique du langage, il faut reconnaître que celui-ci n'a de signification pour le travail psychanalytique que dans la mesure où le discours est dynamisé par des affects. Même si le langage est central pour le savoir psychanalytique et essentiel à sa pratique, les mots seuls ne sont pas les éléments fondamentaux du déroulement de son processus. La fonction interprétative de l'analyste dépend de sa capacité d'entendre non seulement ce qui est dit, mais aussi, peut-être surtout, ce qui n'est pas dit. Sa capacité du message latent du discours du patient est rendue possible par la verbalisation, certes, mais aussi par ce que l'analysant communique affectivement, voire corporellement. Dans son écoute de soi-même, il est également essentiel que l'analyste soit bien à l'affût de ses propres messages affectifs et corporels. Ce n'est que dans un deuxième temps que la somme de cette écoute, pour partielle et partiale qu'elle soit, peut être mise en paroles. La plupart du temps, ce travail psychique, cette élaboration-perlaboration de la part de l'analyste ne fournissent que des hypothèses flottantes concernant le théâtre et les scènes psychiques qui s'y déploient. »*

**I. Le temps / l'espace de l'archaïque et la communication primitive**

De quelle zone psychique parlons-nous, lorsque nous disons qu'un patient transfère des éléments primitifs, d'ordre archaïque sur le thérapeute? Archaïque énigmatique, l'archaïque presque intouchable, impensable, insaisissable, inimaginable ; l'archaïque qui se retrouverait,

comme disait Bernard This, au commencement, à l'origine, aux sources de toute source, au point de départ de toute la vie, qui nous accompagne, qui nous donne les repères, la matrice de l'existence. Mais, plus spécifiquement, au commencement de *quoi*, se demande l'analyste, quant il ressent la souffrance de son patient au-delà de cette limite psychique pensable, analysable. Au commencement de sa naissance, de la vie fœtale, de la conception, d'avant la conception, de l'inconscient maternel et paternel, de sa filiation, de son arbre de vie? Le temps et l'espace archaïques, la matrice affective et fantasmatique originaire, dans laquelle Psyché advienne – jusqu'au où s'étend-elle ? Comment pourrait-on saisir la communication profonde, intime, presque inaudible d'un inconscient à l'autre, le silence, le non-dit, l'inaudible qui se retrouve dans la relation analyste – analysant ?

Dès les années '70, Michael Balint, Donald W. Winnicott, Nicole Fabre, Masud Khan, Marion Milner – parmi d'autres, surtout dans la clinique des psychoses et des états-limites – ont donné des sens possibles à la communication primitive et au temps de l'archaïque : c'est un temps antérieur à la différenciation du moi, donc antérieur à la parole. Temps d'avant l'Œdipe bien sûr, et d'avant le prégénital. Temps et zone du "défaut fondamental" précise Michael Balint. Défaut parce que l'analysant dit qu'il "a le sentiment d'avoir en lui un défaut qui doit être réparé. Il le ressent comme un défaut, un manque, et non comme un complexe, un conflit ou une position ; une *absence* de quelque chose d'essentiel pour son développement, sa maturation. Cette zone du défaut fondamental s'inscrit dans le cadre d'une relation très primitive et très particulière, quand tous les événements qui s'y produisent appartiennent à une relation exclusivement à deux personnes. La force dynamique qui opère à ce niveau – disait Balint - n'est pas de l'ordre du conflit, et le langage adulte est souvent inutile ou trompeur parce que les mots n'y ont pas toujours leur sens conventionnel agréé.

A la lumière des recherches psychanalytiques qui se sont poursuivies au long des dernières décennies sur la psychose, les états-limites, et aussi sur la relation précoce entre le bébé et l'environnement maternant, sur ses effets maturatifs ou pathogènes, sur les particularités du traitement de ces derniers, sur le cadre analytique dans les cures avec les

patients non-névrotiques, l'archaïque est considéré comme une zone qui prendrait fin avec la différenciation entre soi et l'autre, *Self – Other Self*, Me – not Me, avec la constitution de l'objet interne – donc de sa permanence - et de l'objet externe, avec la constitution du sentiment d'identité, d'être, d'exister. Le temps et l'espace archaïque, le vécu archaïque dont nous parlons ici, c'est un temps – espace du commencement du Psyché – soma – esprit, d'où émaneraient les vécus, ressentis, déplacés, transférés sur l'analyste. Qu'il s'agisse de Mélanie Klein, avec sa théorie des positions (schizo-paranoïde et dépressive), de Donald W. Winnicott avec son concept d'espace transitionnel que la mère établit pour l'enfant entre elle et le monde (et aussi la première possession non-Moi, les processus de maturation, l'intégration du Moi etc.), de Didier Anzieu – son concept du "moi-peau", les notions de frontière, de limite, de contenant, la psychanalyse de la transitionalité, ou de Thomas Ogden – la position autiste-contiguë et le sujet analytique - tous ces chercheurs, pédiatres, psychanalystes, et tant d'autres, ont apporté des pierres éclairantes pour la compréhension de ce qui se joue dans cette période archaïque du développement au niveau des frontières, limites, *borders* de l'espace psychique.

Récemment Albert Ciccone et Marc Lhopital ont proposé une sorte de synthèse des travaux sur ce sujet explorant les processus psychiques en œuvre à l'aube de la vie. Ils distinguent trois étapes qui se succèdent – tout en s'interpénétrant – au cours de la première année de vie. Ces étapes ou positions, sont à comprendre non pas comme des stades se succédant les uns aux autres, mais plutôt comme des inclusions, chaque étape représentant un ensemble de phénomènes contenus dans l'étape suivante où ils continuent d'œuvrer. Les auteurs insistent sur la nature dynamique de l'organisation psychique oscillant très tôt d'une position à l'autre. La psyché ne reste pas figée dans une étape (ou position) exclusive, mais elle oscille, attirée par des tendances plus ou moins opposées ou antagonistes. À l'intérieur de chaque étape, la psyché occupe et expérimente plusieurs positions, certaines plus archaïques, plus narcissiques c'est-à-dire que la libido est centrée sur le moi, et d'autres plus objectales. En fait, ces oscillations plus ou moins marquées, plus ou moins longues, existeront tout au long de la vie, et a fortiori pourront-elles avoir lieu dans le

déroulement non seulement de l'analyse mais aussi d'une même séance. Enfin, les auteurs soulignent la double condition à l'altération du développement psychique : "ces altérations, ces "accidents" résultent de la rencontre entre un environnement maternal en difficulté pour assurer sa fonction d'avoir à contenir et à nourrir psychiquement le nouveau-né, et un nouveau-né déficient dans sa capacité à profiter des qualités psychiques de son environnement maternal ou de les stimuler (un handicap constitutionnel … étant en partie tributaire du vécu protoémotionnel in utero). On retrouve ici la notion winicottienne d'ajustement nécessaire de l'interaction "suffisamment bonne", le *holding*, et *l'objet prezenting* ou le concept d'accordage affectif proposé par Daniel Stern.

Joyce McDougall, dans son article « Contre-transfert et communication primitive » (voir *Plaidoyer pour une certaine anormalité*) [6], se demandait ce qui se passe avec les patients qui sont gravement affectés, dès le début de leur vie, par des traumatismes précoces, plus précisément, des événements qui se sont produits avant l'acquisition du langage, au moment quand l'enfant communique par des signes. Elle ajoute ici qu'on ne peut pas parler d'une communication s'il n'y a pas un Autre pour entendre ces signes, les déchiffrer, les donner un sens. C'est pour ça qu'on dise que la première réalité et la première relation de chaque enfant c'est l'inconscient de la mère. Les traces de cette première relation/ communication ne sont pas déposités dans le préconscient, et donc elles ne sont pas accessibles à la remémoration, parce qu'elles n'ont pas jamais eu lieux dans la chaîne symbolique, ces traces préverbales ne s'expriment pas par des fantasmes refoulés, et donc elles ne se retournent pas pour réaliser un sens dans un symptôme névrotique. Les événements traumatiques de l'*infans* se réfèrent aux refoulements et aux clivages primaires. Dans cette période de vie, la souffrance psychique ne se distingue pas de la souffrance physique. Le discours métaphorique des certains patients psychotique, précise Joyce McDougall, comme les manifestations psycho-somatiques, nous offre plusieurs exemples. Nous avons besoin de comprendre la communication primaire mère – enfant, inhérente dans la relation analytique, dans les formes de transfert – contretransfert symbiotique, limite, paradoxale. Chez ces patients, n'importe quelle liaison avec une émotion, une situation ou une représentation qui risque de faire revivre la

situation catastrophale originaire est soudainement coupée, éliminée du psychisme, et le sujet souffre un trouble au niveau de la pensée verbale. Le sujet ne saura jamais laisser un espace nécessaire pour saisir ces pensées inconscientes ; dès que leurs schéma d'affect ou de représentation est évacuée au-delà de psyché, il passe répétitivement, sans aucune transition, aux comportements qui couvrent le vide laissé par le rejet et qui, sans doute, assure aussi une fonction de décharge. Dans ce sens-la, nous dit Joyce McDougall, le parlé peut devenir un comportement.

Chez les patients non-névrotiques, la parole comme acte cherche d'agir sur l'autre/l'analyste, d'arriver chez celui qui entend, de le mouvoir, de l'invader, et c'est pour ça que même l'association libre devient inopérante. Parler c'est pour lui une décharge de la tension douloureuse, par l'intermédiaire d'un langage qui a comme but de *partager* avec l'autre ce qui e du non-dit, l'indicible : le mot cherche plutôt de partager les vécus, les émotions, les affects, que de communiquer des idées. C'est une demande d'être *entendu*, et pas écouté.

**II. Visages et expressions du transfert – contre-transfert archaïques**

Les mouvements transférentielles archaïques s'expriment surtout par des sensations, par le sensoriel, les émotions vagues, certaines sans nom ou à peine avec un nom, communiquées par des gestes, des attitudes, mimique, regards, comportements, actes, passages à l'acte, états psycho-somatiques, le corps parlant ce que le discours verbal nu ne peut pas dire. Les silences ou les paroles sont interrompues par un souffle lourd, ou par des arrêts, des sons, des onomatopées, des exclamations et interjections, des consonnes agglutinées, des gestes saccadés, stéréotypes. C'est par un langage méta-verbal qu'ils peuvent communiquer ce qui n'a pas encore atteint la symbolisation, la verbalisation.

Sacha Nacht nous disait que seul le silence pourrait donner accès au vécu archaïque : l'expérience du "retour à l'union fusionnelle, écrit-il, ne s'exprime pas et c'est ce qui la rend plus difficile à déceler. Cette relation non verbale née jadis dans le silence de l'indéterminé, de l'indéfini, ne peut retrouver vie que dans le silence. Y aurait-il un langage spécifique,

privilégié, qui permettrait d'exprimer les vécus archaïques ? Nicole Fabre souligne qu'il s'agit "d'un langage fondé sur l'image", et non sur le mot ou le son, pour exprimer/métaphoriser puis symboliser les vécus archaïques ; le contenu de ces silences lorsqu'un langage fondé sur l'image permet en quelque sorte de remonter du verbal à l'infra-verbal, puis de revenir de l'infra-verbal au verbalisable. La remontée vers la chose indicible par la voie de l'image chargée d'affect et d'émois archaïques est retrouvée aussi dans la relation analyste - analysant. Comme si l'imaginaire sollicité par la proposition de "dire avec des images", ou plus précisément de "rêver-éveillé" au cours d'une séance d'analyse, avait la capacité d'ouvrir une voie pour dire l'indicible, mobilisant ainsi la problématique inconsciente du sujet. Celle-ci peut alors s'exprimer, prendre sens, se métaboliser. Ainsi les analyses proposant et utilisant le rêve-éveillé en séance comporteraient une originalité dont l'une des dimensions – et pas la moindre – serait de proposer un langage fondé sur l'image, langage privilégié pour exprimer des sensations, des ressentis corporels, des terreurs "sans nom" comme le dit Winnicott, appartenant au vécu archaïque. Une mère doit être capable d'atteindre cet état d'hypersensibilité dans son attitude vis-à-vis du nourrisson, pour s'en remettre ensuite. Cette capacité de rêverie de la mère permettrait au nouveau-né "de projeter dans la mère les sentiments monstrueux qu'il éprouve, par exemple le sentiment qu'il est en train de mourir, et de les réintrojecter après qu'ils aient été transformés par la mère. Si la projection n'est pas acceptée par la mère, le petit enfant a l'impression que son sentiment de mourir est dépouillé de toute la signification qu'il peut avoir. Il réintrojecte alors non pas une peur de mourir devenue tolérable mais une terreur sans nom". Ce processus fonctionne sans doute de la même façon dans la situation analytique. Dans cette hypothèse, la capacité de rêverie de l'analyste, serait alors la condition de la naissance – ou de la réparation/restauration – psychique du patient ; la proposition de rêver éveillé, – puis d'accueillir et partager le rêve du patient – (particulièrement le patient fixé/régressé à ces étapes archaïques) reproduit en quelque sorte les conditions de cette rêverie partagée nécessaire à la maturation psychique, permettant l'élaboration du Moi-peau, à travers ses phases de contenant, de symbiose, avant d'arriver à la constitution de l'enveloppe différenciée. La capacité de rêverie maternelle (ou du

thérapeute) permettrait la mentalisation de l'expérience, et l'accès progressif à l'activité de pensée symbolique.

### III. La capacité de rêverie de l'analyste

L'analyste possède – peut-être plus que d'autres – cette capacité de rêverie; c'est son écoute spécifique, réverbérant, des fantasmes, des rêves, des vécus, des angoisses, des émotions, des actes-symptômes de son patient qui va lui permettre d'accueillir le monde de son patient, puis va le conduire à reconstruire intérieurement en images les mots entendus.

L'analyste "rêve-éveillé" va donc être le passeur, l'accompagnateur qui favorise de manière spécifique l'aller vers les contrées anciennes, archaïques, il va être celui qui va accueillir les angoisses, les rages et qui, grâce à sa capacité de rêverie va les retenir en lui, restituant au patient les angoisses transformées, devenues angoisses tolérables, comme jadis, la mère, (l'environnement maternal), aurait dû le faire. Mais, il doit être aussi celui qui assure le retour, l'expérience symbolique de la sortie, de la différenciation et de la séparation des expériences d'interpénétration et de fusion. Il les pose pourrait-on dire, en parlant de ce contenu imagé, au même niveau que le patient, en utilisant dans ses éventuelles relances le même langage, qui peut évoquer le magma, ce qui colle et englue, ou un langage comme infantile, non formé. Il pose encore les jalons de la sortie, lorsque plus tard, il propose des interprétations, des prises de sens. Fondamentalement, le chemin vers la sortie de l'archaïque passe par le désir du thérapeute. C'est lui qui est porteur et mobilisateur du projet de sortie de la symbiose, donc de la séparation. Un piège existe : celui de se sentir trop bien dans cette relation duelle, dans cette interpénétration, dans cette rêverie partagée, – qui caractérisent ces transferts et contre-transferts archaïques – et de vouloir alors, inconsciemment, y rester. Si l'on peut compter sur l'effet maturatif propre au patient, c'est qu'on pense le projet du thérapeute de vivre la séparation, de sortir de l'état archaïque, qui va aider le patient à s'en sortir lui-même. C'est le sujet qui doit se séparer et non l'objet dit Winnicott. Nicole Fabre ajoute : "Le patient ne peut devenir autonome que si le thérapeute est prêt à le laisser aller". C'est essentielle

aussi l'expérience de la séparation associée à la vraie douleur dépressive de la perte de l'objet. Un autre piège serait celui de vouloir en sortir trop tôt de l'archaïque. Toute intervention interprétative faite trop tôt ne pourrait être vécue que comme proposition, voire exigence de séparation, de rejet, et de fait source de morcellement et de mort pour le sujet – dans la mesure où ce n'est pas lui qui en a pris l'initiative. Outre le temps, la patience, le nécessaire ressourcement personnel du thérapeute qui permettent que le thérapeute puisse se maintenir aussi longtemps qu'il le faudra là où est le patient, pour qu'il puisse plonger avec lui tout en restant sur la rive pour reprendre une expression de Nicole Fabre, il est donc nécessaire que l'analyste reste fidèle à son projet "d'aller vers un progrès".

Il est important de différencier le temps "suffisamment long et bon" ou une distance optime (Glen Gabbard) nécessaire à la reconstruction ou à la construction de ces parties archaïques de la personnalité, de ce qui serait répétition.

### IV. Sens et non-sens du silence dans l'analyse

Sans aucun doute, le silence se retrouve dans chaque moment d'une cure analytique, il est la matrice dans laquelle se configurent le discours parlé ou non-dit de l'analyste et de l'analysant. Le silence de l'analyste permet, premièrement, la création d'un espace pour soi-même et pour le patient, un espace de rencontre inconscient – inconscient, il témoigne de sa capacité à supporter (contient, soutient), sans y être perturbé, contradictions et conflits, motions pulsionnelles, tout en maintenant sa présence lucide à l'analysant et son attitude intérieure positive à son égard. La première vertu du silence analytique, on le sait depuis Freud, est évidemment de permettre à l'analysant de prendre la parole, de dérouler son récit, son aveu, ses mots intimes, dans une tension incitante, facilitante, vitalisante, moyennement frustrante. Si le silence de l'analyste devient une absence paresseuse, morose, hostile, annihilante, froide ou somnolente – par des raisons Ics-PreCs-C, alors le traitement va dériver vers l'échec. Le patient est comme un séismographe pour les silences de son analyste, il va ressentir l'état mental de son analyste, il va signaler plus ou moins directement l'insupportable qui se cache dans ces visages et sens-nonsens

des silences de son analyste, par sa capacité réceptive, par l'intermédiaire de la communication primitive intense dans les cures des cas non-névrotiques. Comme Sacha Nacht nous a déjà signalé depuis les années '50 : "Mon expérience me porte à croire qu'il existe effectivement une communication d'inconscient à inconscient dans les deux sens" [11]. La littérature psychanalytique d'aujourd'hui abonde par des travaux sur la transmission psychique inconsciente. Je voudrais seulement marquer l'originalité de Sacha Nacht d'avoir pris en compte *la réalité des attitudes profondes de l'analyste* (ou comme Ferenczi, sur l'hypocrisie professionnelle), même camouflées derrière le savoir-faire professionnel, comme facteur majeur de la réussite ou de l'échec de certains traitements. Sacha Nacht attribue le caractère irréductible de certaines névroses de transfert, à la complémentarité pathologique d'attitudes inconscientes, par exemple sado-masochistes, entre l'analysant et l'analyste. Inversement le caractère bénéfique de certaines relations, dépend-il de *"ce qu'est"* l'analyste bien plus que de *"ce qu'il dit"* [11], donc que l'être profond de l'analyste (et non son savoir, son acquis technique seul) est un facteur thérapeutique essentiel, éventuellement perçu aussi par une voie *"intuitive-empathique"* (voire "télépathique"). Naturellement, Nacht replace ce type de communication au niveau du stade pré-objectal du développement de l'individu, en fonction de la théorie classique des stades génétiques de la construction psychique. Ce qui ramène à l'époque primitive des rapports mère-enfant, où la dualité sujet-objet n'est pas encore perçue. En fonction de tout ce que l'on sait, sur la réalité des phénomènes régressifs en analyse, et sur la fréquence des transferts de type maternel archaïque, cette constatation de Nacht se réfère à des aspects certainement authentiques de ce type d'expérience, ceux de la "régression". Il est intéressant de noter que Nacht perçoit bien cette hiérarchie des expériences, lorsqu'il constate que l'aspiration à l'union fusionnelle dépasse l'objet parental, pour aller vers l'impersonnel, ce qui aide à liquider la névrose de transfert, précise-t-il. On trouve épisodiquement dans la littérature analytique des notations analogues. Ainsi Winnicott, après avoir analysé la valeur défensive névrotique de la quête d'une non-existence personnelle, par exemple la fuite des responsabilités ou l'évitement de persécutions fantasmatiques,

reconnaît qu' "il peut y avoir un élément positif dans tout cela... (car) ce n'est que de la non-existence que l'existence peut commencer".

Et, si on paraphrase Nacht, on peut dire que le mot retrouve sa vie seulement dans le silence. Peut-être ici on trouve aussi l'explication métapsychologique de la vertu du silence de l'analyste : le silence comme une rêverie, une contemplation, une enveloppe pour le silence ou pour la parole de l'analysant, une source de vie, au moins s'il n'est pas une source de mort.

Cette complexité du nondit-parlé de la relation analytique est bien plus profonde et elle nous *oblige* (dans le sens du travail psychique) à re-penser leur nuances possibles, surtout quant nous réfléchissons sur la clinique, tel comme nous invite à le faire André Green, dans son article extraordinaire « Le silence du psychanalyste » : sur la scène de l'analyse on retrouve simultanément : le dit du patient ; le tu, non-dit et le su du patient ; le tu, le non-dit et le non-su du patient ; l'inaudible et l'inouï du patient ; le dit de l'analyste ; le tu, non-dit et le su de l'analyste ; le tu, le non-dit et le non-su de l'analyste ; l'inaudible et l'inouï.

**Epilogue ou la vérité du silence**

Je vais terminer cet exposé par un retournement à Joyce McDougall, plus précisement, un entretient entre elle et Marie-Rose Moro, etnopsychanalyste, entretient publié en novembre 2001, dans *Le Carnet Psy*, et ses paroles ont marqué presque tous les choix que j'ai fait dans les dernières dix années, et je crois que cet impact a été pareil sur d'autres jeunes psychanalystes aussi:

« ***Marie-Rose Moro*** *: Quels conseils donneriez-vous à une jeune psychanalyste ?*

***Joyce McDougall*** *: Notez tout ce qui vous passe par la tête en écoutant vos patients, tout ce qui vous ressentez, tout ce qui se passe entre vous et l'autre. Notez vos idées, vos associations, vos rêves et vos rêveries. Il faut trouver ce qui est vrai pour soi. Après tout, c'est le but de l'analyse de découvrir sa vérité et ses vérités. Il y en a trente mille.* »

Nous retrouverons toujours Joyce McDougall ici, où nous nous l'avons déjà trouvée, et là-bas, là où nous nous ne l'avons pas encore rencontrée: au-delà et en-deçà du vrai silence.

**REFERENCES**


1. ANZIEU, D. (1985). *Le Moi-peau*, Paris, Dunod, pp. 254-255.
2. CICCONE, A., LHOPITAL, M. (1997). *Naissance à la vie psychique*, Paris, Dunod, pp. 298.
3. FREUD, S. (1975). *Introduction à la psychanalyse*, Paris, Ed. Payot, pp. 443.
4. FREUD, S. (1985). *Pour introduire le narcissisme, La vie sexuelle*. Paris, P.U.F.
5. GREEN, A. (1979). Le silence du psychanalyste, in *La folie privée. Psychanalyse des cas-limites*, Ed. Gallimard, Paris, 1990, pp. 317-346.
6. McDOUGALL, J. (1978). *Playdoyer pour une certaine anormalité*, Ed. Gallimard, Paris.
7. McDOUGALL, J. ( 1982). *Theatres du Je*, Ed. Gallimard, Paris, pp. 186-188.
8. McDOUGALL, J. (1989). *Theatres du corps*, Ed. Gallimard, Paris, pp. 167-197.
9. MORO, M. R. (2001). Entretien avec Joyce McDougall, *Le Carnet Psy*, novembre 2001, Paris.
10. NACHT, S. (1963). *La presence du psychanalyste*, P.U.F., Paris, pp. 29-50.
11. NACHT, S. (1963). Le silence facteur d'intégration, in *Revue Française de Psychanalyse*, 29, pp. 271-280.
12. WINNICOTT, D. W. (1971). *Jeu et realite*, Ed. Gallimard, Paris, 1975.
13. WINNICOTT, D. W. (1963). La crainte de l'effondrement. *Nouv. Rev. Psychan*., 11, 1975, 35-44.

# LE CONTRETRANSFERT DANS LA CLINIQUE CONTEMPORAINE
# UNE SÉANCE DÉPLACÉE

*Michel Vincent*[5]

**Résumé**

*Le cadre peut être vu comme le gardien de l'éthique du psychanalyste. Un « agieren » très banal, un déplacement de séance, couvre puis finalement éclaire un aspect jusque là obscure de la relation transféro/contre-transférentielle. Pour cela un divan bien tempéré, et un cadre précis permettent de « lire » les atteintes que lui font subir patient et analyste. Une séquence montre à l'évidence que le cadre définit avec le patient doit être défendu contre les attaques venues de l'extérieur et de l'intérieur. Le cadre assure l'analyste et l'analysant contre tout caractère déplacé, équivoque, c'est à dire sexualisé, à la part agie qui s'invite dans tout traitent. Ainsi les partenaires d'un projet psychanalytique sont-ils protégés d'une sexualisation redoutable pour le processus psychanalytique.*

**Abstract**

*The setting can be seen as the keeper of the psychoanalyst's ethics. A very banal « agieren », a session displacement covers and then clarifies what was, until that time, a rather obscure aspect of the transference/countertransference relationship. For this purpose, a well-arranged divan and a safe setting enable the "reading" of the touch that the patient and the analyst leave on them. A sequence clearly shows that this setting agreed upon together with the patient must be protected against external and internal attacks. The setting safeguards the analyst and the analysand against any unappropriate, ambiguous, in other words sexual character that may be associated with the action involved in any treatment. Therefore, the partners of the psychoanalytical process are protected against any redoubtable sexualization during the psychoanalytical process.*

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**Mots-clés:** *acting in, enactment, setting, pulsion, représentation de chose, langage*

**Key words:** *acting in, enactment, setting, drive, thing presentation, language*

Au cours d'une analyse, quel psychanalyste n'a pas été conduit, de son fait ou à la demande de l'analysant, à déplacer une séance ? Ce déplacement au regard du cadre, dont le jour et l'heure des séances font parties, est un « agieren » qui va couvrir puis finalement éclairer un aspect jusque là obscure de la relation transféro- contre-transférentielle.

**L'expérience agie partagée**

Le rapport de Jacqueline Godfrin-Haber et Maurice Haber [16] au Congrès des Psychanalystes de Langue Française a retenu mon attention. Etudiant les transformations psychiques, les auteurs prennent en compte l'agir dans la cure. Ils soulignent qu'il s'agit pour eux de tenir compte non seulement dans la cure de l'agir de l'analysant, mais également de celui de l'analyste. Ils définissent ainsi un *échange agi* entre analyste et analysant. L'attente du psychanalyste reste toujours celle du passage d'un registre agi à un registre pensé. Cette réflexion s'appuie sur le travail de Freud [9] sur la répétition qui donne toute son importance à la présence physique de l'analyste comme objet auquel les scénarios mis en scène sont adressés, « donnant ainsi corps et affects aux fantasmes refoulés ». L'hypothèse de travail des auteurs est « d'interroger le réseau d'échanges agis souterrains et de tenter d'en apprécier l'impact sur le processus dans un après-coup qui en permet l'élaboration».

L'exemple clinique de Francine m'a particulièrement convaincu du fait de sa simplicité. Il vient un moment auquel la patiente demande à réduire le nombre de ses séances hebdomadaires de 4 à 3. L'attention est attirée par la multiplicité des raisons invoquées pour justifier cette requête surprenante au regard du déroulement de la cure dont le cadre était jusque là silencieux. L'effet produit sur l'analyste est noté, mais noté aussi l' intensité hors mesure de cet effet. Dans ce contexte l'analyste doit s'absenter brièvement pour des raisons personnelles. Ce temps dont

l'analyste doit disposer va inclure le temps d'une séance de Francine. L'analyste se reproche alors une désinvolture qui ne lui ressemble pas. Supprimer une des quatre séances réalise le souhait exprimée par la patiente. En fait c'est l'inverse qui se produit, Francine se sent désemparée, angoissée car elle tient à ses quatre séances et à son analyste. L'agir de l'analyste a produit une rupture du cadre dont les effets vont conduire à une élaboration de l'échange agi jusque-là. Francine s'était montrée particulièrement complaisante, collaborant docilement, une analysante 'modèle'. Mais voilà que se montre une fillette opposante, revendicatrice auprès d'une mère dont elle avait souffert de la froideur que maintenant elle prête à son analyste. Ainsi se découvrit le souvenir effacé d'une mère malheureuse imposant son malheur à sa fille et au père de sa fille, ce que dans une identification primaire de Francine à sa mère, la patiente avait imposé à son analyste. Ce mouvement ouvre la possibilité d'un renoncement libérateur à cette identification primaire au prix d'une prise de conscience certes pénible.

Les auteurs ayant souligné la pression exercée par Francine sur l'analyste, voient dans la réponse inconsciente de l'analyste une manifestation agie instaurant un '*échange agi* souterrain'. Cet échange entre dans un réseau d'agis croisés dont les auteurs considèrent qu'ils contribuent avec les formulations verbales du travail analytique, et en articulation avec lui, aux transformations psychiques attendue de la cure. C'est à l'analyste qu'il incombe d'élaborer cette aspect de la cure, le plus souvent après un temps de maturation pendant lequel l'effet de l'agi et le sens de celui-ci échappent encore aux protagonistes. André Green [20] le dit bien : « le moment ou cela se passe n'est pas le moment ou cela se signifie ». Je montrerai plus loin combien Freud nous a mis sur la voie qui nous permet d'accueillir ces échanges agis qui sont parfois beaucoup plus discrets que ceux présentés ici.

Au cours du même Congrès, Marie-France Dispaux [2] prolonge cette examen par celui des sources de l'interprétation. Les étapes de la découverte freudienne y sont rappelées [6] combler les lacunes de la mémoire, (1914g) [9] transformer la compulsion de répétition à partir de l'interprétation dans le transfert qui permet le transformation de la répétition en une répétition en acte dont l'élaboration conduit par

l'interprétation du transfert au souvenir. Enfin et plus modestement le travail de reconstruction [14]. En France les travaux de César et Sara Botella décrivent un état de séance entre jour et nuit permettant de favoriser chez l'analyste un accord dans une identité de perception avec le patient. Michel de M'Uzan (1994) décrit un système paradoxal. Celui-ci résulte de la régression acceptée par l'analyste qui entre en identification primaire avec le patient. Ceci implique que l'analyste tolère une relative dépersonnalisation, laquelle comporte un certain effacement des frontières du moi de l'analyste. Une chimère est alors constituée par les inconscients imbriqués de l'un et de l'autre et permettre un travail fécond d'interprétation. Catherine Parat [25] s'en tient à la formule proposée par Freud d'une communication d'inconscient à inconscient. Elle met ainsi l'accent sur le versant narcissique à partir d'une résonance entre les affects de l'analyste et du patient en attente de liaison avec les représentations verbales appropriées. Ailleurs, dans l'espace analytique anglo-saxon, W. Bion [1] a également insisté sur l'importance de l'engagement émotionnel après avoir élargit notre connaissance de l'identification projective (1962) par la description des fonctions α maternelle et β de l'*infans* ouvrant une voie nouvelle à l'interprétation à partie d'une capacité de rêverie propre à l'analyste. D.W. Winicott [30] en avait aussi donné l'exemple à propos du clivage des éléments masculins et féminins chez l'homme et chez la femme.

**Clinique**

Jacques est un jeune homme qui vient de terminer ses études et qui est entré dans une entreprise nationale dans laquelle les hommes de sa famille maternelle ont fait carrière. Il est venu demander une analyse pour rompre avec l'angoisse que fait peser sur lui le divorce de ses parents quand il avait dix ans. Un jour son père n'était pas à table à l'heure du dîner, sa mère semblait anxieuse et plus silencieuse que d'habitude. Son frère aîné ne lui avait pas lancé un des quolibets sarcastiques dont il avait le secret, et surtout il y avait cette place vide en face de sa mère, à côté de son frère. Sa mère avait annoncé qu'on allait dîner sans attendre. Le dîner terminé, son frère avait demandé si Papa rentrerait. Sa mère avait écarté la question et envoyé son frère et lui dans leur chambre préparer leurs affaires

de classe pour le lendemain. Quand elle est venue leur dire bonsoir elle avait les yeux rouges, mais elle les a embrassés comme d'habitude, sans répondre à la question timide de Jacques demandant ce qui se passait. C'est ainsi que son père avait délaissé femme et enfants. Par la suite, des semaines plus tard son père qui avait laissé une simple lettre à son épouse repris contact pour demander à voir les enfants. Ce fut le début d'une période difficile de négociation de droits de visite contre le règlement d'une pension alimentaire, et de l'organisation de week-end et de vacances pour lesquels Jacques ne savait jamais très bien si son père viendrait ou non comme il l'avait dit.

Jacques restait cependant attaché à son père qui recevait son frère et lui plusieurs fois par an. Il n'a jamais fait de commentaire permettant de donner un sens à son départ, si ce n'est celui d'une mésentente avec la mère de Jacques. Ce qui pou jacques ne constituait en rien une explication, pas davantage que le jugement souvent répété par sa mère que leur père était égoïste. Dans les années récentes son frère s'est marié et le mariage a fait l'objet de tentatives de la part de Jacques de revenir avec son frère sur le départ de leur père. Mais la question n'eut jamais de suite entre eux.

Pendant la fin de ses études Jacques s'était lié avec une étudiante major de la promotion qui suivait la sienne. Il avait été heureux de se découvrir virile avec elle, et leurs familles accueillaient bienveillamment leur relation. Cependant cette relation lui devenait de plus en plus pesante. Alors il a espacé leurs rencontres, manifesté son ennui en sa présence, et fait tant et si bien qu'ils finirent par convenir de ne plus se voir. C'était il y a deux ans. Parfois quand il se sent seul, il pense à elle avec regrets. Mais très vite le souvenir de l'ennui partagé avec elle le ramenait à la morosité qui est la sienne depuis plusieurs mois.

Nous avons été conduits à confirmer son projet de faire une analyse et nous avons examiné comment cela serait possible. Rien n'a échappé à une réticence aussi discrète que certaines : ni le jour, ni les heures des séances, ni le temps de leur règlement ne purent être décidé simplement. Nous sommes cependant parvenu à un accord, mais non sans que des retouches ne soient souhaitées par lui tantôt à propos d'une heure, tantôt pour un jour de séance, ou encore du jour convenu pour le règlement des séances. Pendant les mois suivants, la régularité des séances me permet de

me figurer la vie d'un homme jeune partagé entre ses projets et ses histoires d'enfant. Le cadre était finalement respecté et le garçon parfois vindicatif du début avait laissé la place à un analysant agréable jusqu'à ce que quelques mois plus tard il advint que je sois empêché de le recevoir pour une raison personnelle. Jacques en pris note généreusement et demanda si je pouvais déplacer cette séance. Ce que je fis. Trois semaines plus tard lorsque je le reçois à la séance régulière, le lendemain du jour qui ne m'avait pas permit de le recevoir et pour lequel nous avions convenu d'un déplacement le jour suivant, il m'annonce être venu pour sa séance et avoir été très contrarié de trouver la porte close et restée fermée. C'est seulement au cours de la séance qu'il s'est rappelé que nous avions parlé de mon absence et du déplacement de cette séance au lendemain. Ce jour là il ne fut pas possible d'obtenir quelque association que ce soit sur son « oubli » qui avait motivé des reproches contre moi, porté qu'il était par un autre fil associatif concernant ses relations féminines.

Il y avait cependant un fil rouge réunissant ces différents évènements à l'état de la relation transférentielle et à ma position contre-transférentielle.

**Acting/Enacting/Enactment / Enaction**

La notion d'enaction n'est pas encore très familière en France. Elle le doit certainement à son origine anglaise dont les traductions peuvent connaître des retards. J'en ai introduit l'usage dans mon travail car elle me semble féconde quand elle est associée à celles d'agir et de résistance [29]. Un dictionnaire anglais en propose les définitions suivantes (1) Le décret qui donne effet à une loi, (2) L'acte juridique, par lequel est promulgué un décret, qui permet de donner son effet à une loi, (3) L'interprétation d'un rôle, dans une pièce de théatre. Cette acception est rare ajourd'hui, (4) rare également aujourd'hui l'usage du mot pour exprimer le fait d'être engagé dans une action : « en action ». Les deux dernières définitions apparaissent clairement sans le Hamlet de Shakespeare :

*Hamlet : My Lord, you played once i'th'university, you say ?*
*Polonius : That did I, my lord, and was accounted a good actor*
*Hamlet : What did you enact?*

*Polonius : I did enact Julius Caesar. I was killed I'th'capitol, Brutus killed me*
(Hamlet, acte III, scène II, vers 91-96)

La scène se produit alors que la cour entre pour assister à la représentation d'une pantomime préparée par Hamlet pour confondre le frère de son père, son oncle d'avoir tué le Roi, son père ; pour épouser la Reine, sa mère. Il faut se rappeler aussi de l'indication donné par André Green (1982) qu'il s'agit d'une scène dont Hamlet a annoncé qu'il devait y paraître fou. Il s'agit non seulement du souvenir d'un crime, mais aussi de ce que le mobile en a été le désir pour la femme.

La proposition d'introduire le concept d'enaction en psychanalyse semble dû pour l'essentiel à Joseph Sandler [28] qui constatait avec amertume que les concepts de la psychanalyse repris par les psychiatres étaient vidés de leur sens. Il en va ainsi de la notion d'acting qui désigne une action faite pendant la séance (*acting in*), ou en dehors de la séance (*acting out)* avec la particularité d'être totalement inconsciente quand à sa signification. Les psychiatres utilisant la notion dans un contexte phénoménologique, sans référence aux différences de qualités chères aux psychanalystes entre pré-conscient/inconscient et conscient il devenait nécessaire de rétablir une terminologie qui rétablisse l'usage freudien de la notion de « *mise en acte* » introduite sous le vocable « Handeln » ordinaire en langue allemande pour « agir » dans *la Psychopathologie de la vie quotidienne* [7] puis « Agieren » à propos du cas Dora [8].

S'agissant du patient, Freud (1940-38) indique à propos du transfert que tout se passe comme si le patient agissait devant nous au lieu de seulement nous renseigner [15]. Il s'agit clairement de l'actualisation d'un fantasme inconscient qui trouve par le transfert à se répéter, sous l'effet dois-je ajouter d'une invitation contre-transférentielle.

Les auteurs post-kleiniens ont attiré l'attention sur la relation entre l'acting out et les expériences pré-verbales de Sergueï Pankeiev, l'homme aux loups. Ainsi W. R. Bion [1], H. Rosenfeld [26], D. Meltzer [24] et L. Grinberg [22] [23]. Mais à cette époque la notion d'enaction n'a pas cours encore. Ces auteurs proposent alors une extension des acceptions du concept d'acting.

En France Julien Rouart [27] inscrit la problématique de l'agir dans le cadre d'une relation transférentielle qui comporte l'éventualité d'un déplacement sur un objet latéral. Plus tard Jean-Luc Donnet [3] reviendra sur la latéralisation du transfert en dehors du site analytique qui fait vivre sur un objet substitutif un aspect du transfert. Il faudra encore du temps pour que l'analyste reconnaisse sa part d'agir que le cadre conduit à prendre aussi en considération.

**Schéma des quatre territoires**

Ce schéma a été proposé par André Green [21] dans le prolongement d'un travail antérieur consacré à « la représentation de chose entre pulsion et langage » (1985-1995). Les quatre territoires sont (1) Le soma, (2) L'inconscient, (3) Le conscient et (4) La réalité extérieure. Le soma nous rappelle ici la tentative faite par Freud pour définir le vocable de la langue allemande qui devait prendre une importance particulière dans la suite de son œuvre, Trieb. Nous pouvons lire [10] « … la pulsion nous apparaît comme un concept frontière entre animique (ou psyché) et somatique, comme un représentant psychique des stimulus issus de l'intérieur du corps et parvenant à l'âme (ou la psyché), comme une mesure de l'exigence de travail qui est imposé à l'animique (ou psyché) par suite de sa corrélation avec le corporel ».

Je voudrai introduire ici un premier commentaire à propos du soma qu'il faut distinguer du corporel (*body* en anglais). Le soma est la source des excitations ou stimulus émanant du corps. Le psychanalyste n'en a pas la responsabilité directe. Le psychanalyste ne peut pas l'ignorer mais ce sont les médecins qui en sont responsables en partage avec un certains nombres de spécialistes des sciences de la vie. Il en résulte une importance capitale de ce que André Green désigne du nom de *frontière somato-psychique* séparant le soma de l'appareil psychique que nous pouvons comprendre comme la limite sur laquelle se fonde la métaphore de la pulsion qui aborde la psyché pour y travailler.

Une autre remarque concerne la topographie ainsi exposée. Le scéma proposé par André Green réunit les deux topique, la première ICS-PCS – CS, et la seconde Ça-Moi-Surmoi.

La première a ses racines dans la première partie de l'œuvre de Freud, alors qu'il n'était pas encore question de psychanalyse, mais de son intérêt pour l'aphasie qui l'a conduit à écrire son « Projet pour une psychologie scientifique » [4]. La psychanalyse est apparue avec les Etudes sur l'hystérie [5] et L'Interprétation des rêves [6]. C'est là que nous trouvons la description de l'appareil psychique conçu comme une métaphore destinée à faciliter la représentation de la diversité des processus psychiques sources d'angoisse et de souffrance et par suite d'imaginer les moyens techniques pour y remédier.

La première version de l'appareil psychique est définie dans une perspective systémique. Elle comporte des systèmes décrits selon leur qualité : conscient, pré-conscient et inconscient transcrits en tant que système lié de façon cohérente ou non par CS-PCS-ICS.

La deuxième version est celle des différentes parties de la personnalité [13] liant (1) le 'ça' qui a ses racines dans le soma dépourvu de représentation, (2) Le 'moi' différencié, et la seconde partie est consciente, en relation avec le monde extérieur, (3) le 'surmoi' plonge dans le ça et est en relation avec les deux parties du moi.

Le premier territoire est celui du soma. Il est le site originaire des excitations endo-somatiques qui vont gagner la *frontière somato-psychique* et qui parviennent ainsi à la limite, ou encore au bord de l'âme/psyché qui leur donnera leur signification de Représentant Psychique (R.Ψ.) de la pulsion encore inconnaissable car dépourvu de représentation.

Le second territoire est celui de l'inconscient [11]. Le 'représentant psychique (R.Ψ.) de la pulsion' pourra entrer en association avec les traces des 'Représentations de Chose' (R.C.) (ou représentation d'objet, R.O.) restées d'expériences antérieures de satisfaction et auxquelles la transmission de la charge pulsionnelle du R.Ψ assure la transformation de la R.C. en représentation de désir (ou représentation-but). Les Représentations de chose sont accompagnées de leur quantum d'affect (Q.A.) et associées a un contenu, le représentant idéationnel (R.I.) des anglo- saxons, le sein par exemple dans l'hypothèse d'une pulsion orale. Ils appartiennent l'un et l'autre à l'inconscient. Ils sont susceptibles de transformations. Ces transformations font suite à des régressions qui leur apportent une part de l'expérience acquise au cours de l'histoire et aussi

des interprétations reçues des personnages significatifs à commencer par les parents et leurs substituts parmi lesquels le psychanalyste. L'attente de satisfaction peut être heureuse de la rencontre d'un représentant psychique (R.Ψ.) et d'une représentation de chose (R.C.) disponible assurant la satisfaction temporairement sur le mode de la réalisation hallucinatoire du désir. e représentant idéationnel (R.I.) et le quantum d'affect (Q.A.) suivent un trajet régrédient à travers le *préconscient* qui est alors envisagé moins comme une limite que comme un espace permettant la liaison entre les représentations issus des Représentations de Chose' (R.C.) et les représentations de mot (R.M.) qui font de cet espace un espace orienté vers la devenir conscient et un espace de pensées appelant la formation de liens entre elles et la constitution d'un appareil à penser les pensées.

Le troisième territoire est celui de la conscience psychique (C.Ψ.). Les quotas d'affects se traduisent ici en plaisir-déplaisir. Les représentations de chose (R.C.) associées aux représentations de mot (R.M.) peuvent suivre soit une voie régrédiente sous l'effet des refoulements par attaque contre le lien entre (RC) et (RM), soit elles suivent la voie progrédiente dans la communication avec l'objet de la réalité extérieure. André Green a souligné l'existence de double représentance à plusieurs niveaux :

Double représentance de chose consciente et inconsciente

Double représentance de chose et de mot dans le conscient

Double représentance de chose et de pulsion (par la représentation de chose (RC) investie par le représentant psychique de la pulsion (R.Ψ.) dans l'inconscient.

La représentation de chose est ainsi au centre de l'activité psychique, non sans qu'un degré supérieur ne puisse être atteint par le langage. C'est à ce dernier que nous devons en effet que nos processus de pensée soient rendus perceptibles. A la limite entre le territoire conscient et la réalité extérieure une *barrière des stimulus* protège l'appareil psychique des perceptions. Freud considérait qu'elle est représentée dans le moi par les idées et jugements. Elle assure une transition avec la réalité externe. Elle est particulièrement importante dans le travail avec les patients psychosomatiques car elle permet d'évaluer leur capacité de relation avec de nouveaux objets que le psychanalyste est appelé à représenter.

Le quatrième territoire est celui de la Réalité extérieure, l'espace dévolu à l'objet, comme objet de perception, et objet sur lequel se porte la recherche de satisfaction d'une activité incessante des stimulis endo-somatiques qui ont connu les transformations imposées pour que le représentant psychique (R.Ψ.) de la pulsion rencontre les modalités de satisfaction offertes par suite du développement de l'appareil psychique.

Revenant à Jacques, mon absence la jour prévu pour être celui d'une séance, mon acceptation d'un changement pour que de la séance ne soit pas abandonnée, mais déplacée a transformé la situation. Je n'étais plus perçu comme un substitut tranférentiel de l'image maternel tout à ses soins dans une période rendue difficile parce qu'il comprenait bien le désir des jeunes femmes qui s'attachaient à lui avec le projet de faire un enfant alors que lui ne partageait pas du tout une telle perspective. Il était heureux de partager leur intimité, et des projets culturels. Mais il était bien certain de ne vouloir aucune famille, citant en exemple des tantes heureuses d'être restées sans enfants. La séance manqué a révélé à travers les reproches qu'il m'a faits de l'avoir laissé tomber comme son père le jour où il a quitté la maison familiale sans retour... Ce fut pour lui un abandon. La situation transférentielle nouvelle ne lui permettait plus de se lier à la jeune femme qui retenait maintenant son attention avec ce qu'il a appelé le même égoisme.

**Le cadre gardien de l'éthique du psychanalyste**

Un « agieren » va couvrir, puis finalement éclairer un aspect jusque là obscure de la relation transféro - contre-transférentielle sous réserve qu'un divan bien tempéré par un cadre précis permette de « lire » les éclats que lui porte patient et analyste. Cette séquence montre à l'évidence que le cadre définit avec le patient est si précieux qu'il incombe à l'analyste de la défendre contre les attaques venues de l'extérieur et de l'intérieur. L'établissement du cadre et son caractère bien tempéré (Donnet) [3] assure l'analyste et l'analysant contre tout caractère déplacé, maintenant au sens de sexualisé à la part agie qui s'invite dans tout traitent.

**REFERENCES**


1. BION, W. R. (1962). *Learning from experience*, London, Heinemann, 1962 ; trad. F.Robert, *Aux sources de l"experience*, Paris, P.U.F., 1979.
2. DISPAUX, M.F (2002). Aux sources de l'Interprétation, in *Rev. Franç. Psychanal*., LXVI, 2002, 5:1461- 1496.
3. DONNET, J.L. (1995). *Le divan bien tempéré*, Paris, P.U.F.
4. FREUD, S. (1950a [1887-1902]. Esquisse pour une psychologie scientifique, in *Naissance de la psychanalyse,* Paris, P.U.F., 1956.
5. FREUD, S. (1895d). *Etudes sur l'Hystérie*, Paris, P.U.F., 1956.
6. FREUD, S. (1900a). Le travail du rêve – chap.IV, Sur la psychologie des processus de rêve – chap.VII, in L'Interprétation du Rêve, *O.C.IV*, Paris, P.U.F., 2003; *SE V*.
7. FREUD, S. (1901b). Psychopathologie de la vie quotidienne, Paris, PBPayot, *SE VI.*
8. FREUD, S. (1905[e]). Fragment d'une analyse d'hystérie, in *O.C.VI*, Paris, P.U.F., 2006; *SE VII.*
9. FREUD, S. (1914g). Remémoration, répétition et perlaboration, in *OC. XII*, Paris, P.U.F., 2005 ; *SE XII.*
10. FREUD, S. (1915c). Pulsion et destins de pulsion, in *O.C. XIII*, Paris P.U.F., 1988; *SE XIV*.
11. FREUD, S. (1915[e]). L'Inconscient, in *OC XIII*, Paris, P.U.F., 1988 ; *SE XIV*.
12. FREUD, S. (1918b). A partir de l'histoire d'une névrose infantile, in *O.C. XIII*, Paris, 1988 ; *SE XVII.*
13. FREUD, S. (1923b). Le Moi et le Ca, in *OC XVI*, Paris, P.U.F., 1991; *SE XIX.*
14. FREUD, S. (1937d). Constructions dans l'analyse, in *OC. XX*, Paris, P.U..F, 2010; SE *XXIII.*
15. FREUD, S. (1940-38). Abrégé de psychanalyse, in *O.C. XX*, Paris, P.U.F., 2010; *SE XXIII.*
16. GODFRIN-HABER, J., HABER M. L'expérience agie partagée, *Rev. Franç. Psychanal*., LXVI, 2002, 5:1417- 1460.

17. GREEN, A. (1985). La représentation de Chose entre Pulsion et Langage, in *Propédeutique*, Seyssel, Les Editions de Champ Valllon, 1995.
18. GREEN, A. (1982). HAMLET et Hamlet, une interprétation psychanalytique de la représentation, Paris, Belland, 1982.
19. GREEN, A. (1995). *La Causalité Psychique*, Paris, Editions Odile Jacob.
20. GREEN, A. (2000). *Le Temps Eclaté*, Paris, Les Editions de Minuit.
21. GREEN, A. (2010). Thoughts on the Paris School of Psychosomatics, in *Psychosomatics Today, A Psychoanalytic Perspective*, London, Karnac, 2010.
22. GRINBERG, L. (1968). On acting out and its role in the psychoanalytic process, *I.J.P.*, 1, 1968, 49:171-178.
23. GRINBERG, L. (1987). Dreams and acting out, *Psychoanalytic Quaterly*, 1987, 56:155-176.
24. MELTZER, D. *The Psychoanalytic Process*, London, Heinemann, 1967.
25. PARAT, C. *L'affect partagé*, Paris, P.U.F., 1995.
26. 26. ROSENFELD, H. An Investigation into the need of neurotic and psychotic patient to act out during analysis, in *Psychotic States: a psychoanalytic approach*, London, The Hogarth Press, 1965, rep Karnac Books 1985, trad. *Les Etats Psychotiques*, Paris, P.U.F., 1976.
27. ROUART, J. Agir et processus psychanalytique, in *Rev. Franç. Psychanal*, 1968, 5-6.
28. SANDLER, J. *The patient and the analyst. The basis of the psychoanalytic process*, Madison, Connecticut International Univ Press, 1992; 2nd ed. Revised and Expanded by J. Sandler and Anna Ursula Dreher, 1995.
29. VINCENT, M. (1999-2005). Agir pour penser ou de la résistance à l'enaction, in *Maladie d'Adolescence,* Paris In Press; A actiona pentru a gandi sau rezistenta la enactiune, *A indura adolescenta*, Editura Fundatiei Generatia, 2008.
30. WINNICOTT, D. W. (1971). La créativité et ses origines, in *Jeu et Réalité, l'espace potentiel,* Paris, Gallimard, 1975, pp.101-105 *;* Creativity and its origins, in *Playing and Reality*, London, Penguin education, 1971, 1980, pp.84-88.

# THE COUNTERTRANSFERENCE, THE ANALYST'S PERSONALITY AND THE WAY IN WHICH THE ANALYTICAL RELATION DEVELOPS IN TIME

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*Motto:*

„You could not step into the same river twice."

*(Heraclitus)*

**Résumé**

*Dans cet article l'auteur essaie d'analyser la manière dont l'analyste comprend et gère le contretransfert au fil du temps. L'auteur se demande dans quelle manière le contre-transfert de l'analyste est-il affecté/influencé par son statut professionnel (analyste débutant, analyste expérimenté qui appartient à certaines écoles de psychanalyse etc.) et si le contretransfert est-il affecté par certains événements significatifs de la vie de l'analyste qui puissent se refléter pendant son analyse avec un patient.*

*Il est possible/à désirer/recommandable que l'analyste garde le contrôle sur tous les événements de sa vie, de sorte qu'ils ne pénètrent pas l'espace analytique des séances. Ou, par contre, tout ce que l'analyste ressent et pense pendant son*

**Abstract**

*In this paper, the author tries to analyze the way in which an analyst understands and manages countertransference during time. The author asks herself in which way the analyst's counterstransference is affected/ influenced by his/her professional status (beginner analyst, experienced analyst, belonging to some theoretical psychoanalytical schools, etc); also, if countertransference is affected by some significant events from the analyst's life which can happen during the analysis with a patient.*

*It is possible/wished/recommended that all these events from the analyst's life should be kept under control by the analyst so that they do not enter the analytical space of the sessions; or, just the opposite, everything that the analyst feels and thinks during the*

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*analyse avec les patients, soit être pris en considération et analysé.*
*L'article analysera le contretransfert dans l'œuvre de Winnicott 'The Use of the Object' (Utilisation de l'objet) et le „rôle de miroir de la mère" ainsi que les œuvres de Ogden 'The Analytic Third' (Le tiers analytique), 'The Dream-thinking' (La pensée onirique) et la rêverie.*

*analysis with his/her patients must be taken into consideration and analyzed.*
*The paper will analyze countertransference from Winnicott's writings 'The use of the object' and 'the mirror role of mother' and Ogden's writing 'The analytic third', 'The dream-thinking' and the 'reverie'.*

**Mots-clés:** Contretransfert, le role de miroir de la mere, „utilisation de l`objet", le tierce analytique, reverie.

**Key words:** Contratransference, "mirror role mother", „using of the object", the analytic third, reverie.

Any form of creation, including a paper written by somebody at a moment, bears the mark of the author with all that he or she is at that moment. Sooner or later, the author will go through personal changes and will never be the same person who first wrote that paper.

But what happens between two persons, analyst and analysand, who meet in a certain frame (analytical setting- like the same river) and how does their relationship develop (the analytical relationship-like different water)?

I have in my mind some questions about the analytical relationship and about countertransference topic:

- How does the analyst see his own countertransference?
- How does he try to manage all that he feels and thinks in relation with the patient?
- Is countertransference what is normally understood as the analyst's reaction to the analysand's transference or can it be regarded as something more, which implies all states, thoughts, physical sensations experienced by the analyst during the session?
- Is the analyst's countertransference affected by some data regarding his professional status (beginner analyst, experienced analyst, belonging to some theoretical psychoanalytical school)?

- Is the analyst's countertransference affected by some real life events which he can experience during an analysis (marriage, divorce, birth of children, different losses, different medical problems, the death of someone dear etc.)?

In this paper I will try to answer these questions by keeping in mind the two analytical perspectives towards countertransference. I will refer to Winnicott's writings about "the use of the object" and "the mirror role of mother" and to Ogden's writings about "the analytic third", "dream-thinking" and "reverie".

In our analytic practice we meet patients who know how to use the object, but also patients who haven't experienced this. From Winnicott's point of view, "the use of the object" means the child's/patient's capacity to relate to the mother/analyst as a real object located outside the omnipotent control and also to the mother's/analyst's capacity to let herself/himself be used.

Ogden considers that in the analytical relation the patient's subjectivity along with the analyst's subjectivity generate in the analytical pair an intersubjective experience which creates "the analytic third". This is mainly possible due to the analyst's capacity for reverie. Ogden understands reverie not only from a bionian point of view as being a state of active receptivity of the mother/analyst to all the states that come from the child/patient. Moreover, he considers reverie as a form of mental activity which implies a state of: "*narcissistic self-absorption, distractedness, compulsive rumination, daydreaming and the like*" [6].

Starting from Winnicott's and Ogden's perspectives, I want to suggest that the analyst's capacity for reverie is different in content depending on the patient's capacity to use the object. This means that for a patient who doesn't know how to use the object - but is also at the beginning of the analytic relationship with any other patient-, the analyst's reverie will rather be in a bionian way; this means that the reverie will predominantly be directed towards the acceptance, containing and giving back, in a meaningful way, everything that comes from the patient. On the other hand, in the analytic relationship with a patient who knows how to use the object (whether this was accomplished in the relationship with the patient

or this capacity was acquired before) the analyst's reverie will contain elements, as Ogden mentioned.

Of course, the two sets of reverie are always present and mixed in the relationship with the patients, but what I want to emphasize is the predominance of a certain type of reverie at some patients or in certain stages of the analysis with the same patient.

In the paper, I will give an example with a vignette from a case which shows the interpersonal interaction between analyst and patient and the way in which the analyst uses reverie. Also, I will try to analyze this sensitive topic and the way in which the analyst's personal experience and the degree of professional development affect/influence him in the work with his patients.

**Winnicott's and Ogden's perspective on analytic relation and countertransference**

Winnicott started from his experience regarding the relationship mother-infant in order to understand the analytical relationship.

If we observe two babies, one in his first days of life and the second being 5-6 months old, we will see how different they are not only from the point of view of physical development, but also from that regarding the relationship with their mothers.

In the relationship of a newly-born with its mother we can see what Winnicott said about the primary maternal preoccupation of the mother and also the baby's dependency state towards the environment. What is remarkable when we observe a mother with her infant in the first days is not only the baby's total physical and emotional dependency, but also the mother's complete transfiguration in his presence. There's nothing else around, it's like a state of trance which allows the mother to completely, physically and emotionally, connect to the baby's states and body. If you have previously known the mother, when you see her again after she has given birth to her baby, you wonder: "Is it her or not?" although you know it's her.

We know that the mother's almost perfect nursing to her baby's physical and psychological needs allows him to experience the feeling of

continuity and develop an omnipotence feeling given by the illusion that it has created the breast, although this existed before.

Also, during this first period it is significant for the baby how it is seen by the mother. In 'The mirror role of mother and family in child development"(1967) Winnicott said: *"What does the baby see when he or she looks at the mother's face. I'm suggesting that, ordinarily, what the baby sees is himself or herself. In other words the mother is looking at the baby and what she looks like is related to what she sees there"* [15].Therefore, until a child looks at himself/herself in a real mirror for the first time he/she will have been mirrored in his/her mother's eyes thousands and thousands of times.

In a similar way, Winnicott considers the same aspect in the analytic relationship: *"Psychotherapy is not making clever and apt interpretation; by and large, it is a long-term giving the patient back what the patient brings. It is a complex derivative of the face that reflects what is there to be seen. I like to think of my work this way, and to think that if I do this well enough, the patient will find his or her own self, and will be able to exist and to feel real. Feeling real is more than existing; it is finding a way to exist as oneself, and to relate to objects as oneself, and to have a self as retreat for relaxation."* [14].

In the relationship with certain patients, as well as at the beginning of an analysis, the analyst is mainly preoccupied to see, feel the patient and less, almost not at all to make interpretations. The analyst rather confirms that what the patient tried to say/show has been understood.

What happens later with a 5-6 month old baby?

Unlike the mother-baby pair in the first days, in this period we shall remark a state of relative autonomy. The baby is no longer attached to its mother's breast/body, and we observe how it further experiences other gestures, as playing with its fingers, sucking a thumb, carefully analyzing the movements of its hand, the movement of a toy, moments of prattle which lead to singing and so on. The baby has also experienced small failures of the environment/mother so far but which haven't disturbed it. The mother was sometimes absent from its side or sometimes she did something else in its presence. What a mother observes in this period is the fact that she is not completely connected to her baby's states and that sometimes she can think of something else, including problems, different

happenings from the day, unquietness, but these states don't affect the baby's state.

In "The use of an object and relating through identification" (1968) Winnicott [15] shows the way in which the baby passes from perceiving its mother as a subjective object being under its omnipotent control to seeing its mother as a separate, real object from the external reality. If the mother is real she will be used by her child. The paradox is that in order for the object/mother to be used, it first needs to be destroyed. But between the time of destruction and use, the object/mother needs to survive the destruction, and precisely not to react to the baby's attacks. Winnicott emphasized that: "*It is important to note that it is not only that the subject destroys the object because the object is placed outside the area of omnipotent control. It is equally significant to state this the other way round and to say that it is the destruction of the object that places the object outside the area of the subject's omnipotent control. In these ways the object develops its own autonomy and life, and (if it survives) contributes-in to the subject, according to its own properties."* [15].

All things considered, I believe that Winnicott implicitly believes that the real object meaning the breast/mother is at the same time the subject, because the breast/mother had existed even before the baby's creation and nobody asks "you created or found this". In reality, within a relationship the subject and object coexist.

Coming back to the relationship between the mother and her 5-6 month old baby, we see that this baby knows how to use her mother. We note that the autonomy state of the two takes place in a playing space in which both of them experience different states at the same time: for instance, the baby plays and platters, while the mother thinks of other things that are not related to the baby. This is possible because the mother has survived the baby's destruction and she continues to dream about the baby's experiences and also about her own experiences. In this way, the baby begins to see its real mother different from that under his omnipotent control, as well as play between its outside and inside world.

In a similar way, Winnicott sees the analytic relationship as the patient's possibility to use the analyst and the latter's capacity to be used. In our practice, we have patients who know how to use the object, as well

as patients who didn't benefit from a good-enough environment/mother and therefore didn't develop this capacity. The analyst's task in this kind of cases is more complicated: "*In meeting the needs of such patients, we shall need to know what I am saying here about our survival of their destructiveness. A backcloth of unconscious destruction of the analyst is set up, and we survive it or, alternatively, here is yet another analysis interminable."* [15].

Getting closer to what happens in the analytic relationship, we ask ourselves the following question: Which is the nature of countertransference? What sort of exchange happens between analyst and patient?

Is countertransference what is normally understood as the analyst's reaction to the analysand's transference or can it be regarded as something more, which implies all states, thoughts, physical sensations experienced by the analyst during the session?

It is well-known that Freud wasn't very interested in countertransference, mainly taking into consideration the patient's analysis of transference and the patient's analysis of resistance. The analyst's metaphors of "blank screen" and surgeon are very well-known. In "Recommendations to physicians practicing psycho-analysis" (1912), Freud [3] suggests self-control and caution in the relation with the patient. He says that the doctor has to be untransparent for the patient and just as a mirror not to show anything different from what it is shown. Later, Freud has inferred the more complex nature of the psychoanalytic relationship and he said: *" It is a very remarkable thing that the Ucs of one human being can react upon that of another, without passing through the Cs"* [4].

This analysis of the analytic relationship complexity in which both the patient's and analyst's contribution are seen has been made by many different analysts. I will now make a reference to Thomas H. Ogden who mentioned the dialectical connection, the intersubjective experience created in the analytical relationship and which generated what he called "the analytic third".

In "The analytic third: Working with intersubjective clinical facts" (1994) Ogden [6] starts from what Winnicott said regarding the mother-baby relationship: *"There is no such thing as an infant"[apart from the maternal provision]"* [13]. In a similar way, he considers that: *"in an analytic context,*

*there is no such thing as an analysand apart from the relationship with the analyst, and no such thing as an analyst apart from the relationship with the analysand.*" [6]. Ogden considers Winnicott's statement as intentionally incomplete and it is obvious that both the mother and the baby exist at the same time, as two different physical and psychological entities.

Similarly, in the analytic relationship: *"the intersubjectivity of the analyst-analysand coexist in dynamic tension with the analyst and analysand as separate individuals with their own thoughts, feelings, sensations, corporal reality, psychological identity and so on."* [6]. The purpose is not to identify what comes from one or another, but the intersubjective experience which is generated from the subjectivity of the two.

In this way, the analytic third is "*a product of a unique dialectic generated by (between) the separate subjectivities of analyst and analysand within the analytic setting."* [6]. We have the analyst's subjectivity, the analysand's subjectivity and these two subjectivities jointly create a third intersubjective experience. This experience doesn't mean that the two experience the same state, but that the experience generated by what was said and felt in the relationship leads to a new meaning of things, for both analyst and analysand. Ogden emphasizes that: *"the analytic third is an asymmetrical construction because it is generated in the context of the analytic setting, which is powerfully defined by the relationship of roles of analyst and analysand. As a result, the unconscious experience of the analysand is privileged in a specific way, i.e. it is a past and present experience of the analysand that is taken by the analytic pair as the principal (although not exclusive) subject of the analytic discourse. The analyst's experience in and of the analytic third is, primarily, utilized as a vehicle for the understanding of the conscious and unconscious experience of the analysand (the analyst and analysand are not engage in a democratic process of mutual analysis)."* [6].

But which is the instrument which generates this intersubjective experience?

Ogden considers that the interpersonal experience created by the analytical pair becomes available to the analyst through his own reverie. What he introduces is the experience of reverie in a larger sense: "*I use Bion's term reverie to refer not only to those psychological states that clearly reflect*

*the analyst's active receptivity to the analysand, but also to a motley collection of psychological states that seem to reflect the analyst's narcissistic self-absorption, obsessional rumination, day-dreaming, sexual fantasizing, and so on."* [6]. The analyst's capacity to listen to and tolerate these reveries is important and they lead to a new meaning of what goes on in the analytic relationship. Sometimes, he may feel guilty, embarrassed, ashamed, unreceptive, not understanding and so on, and he may consider that during those moments he didn't work analytically. All these happen because this kind of moments: *"involve a disturbing form of self-consciousness"* [6], but, as he emphasized, the emotional disequilibrium generated by reverie is one of the most important elements of experience for the analyst to get a sense of what is happening at an unconscious level in the analytic relationship. Ogden underlines how complex this capacity for reverie is and especially the analyst's capacity to use it to the benefit of both the analysand and himself in the analytic session. The analyst's reverie requires from his part tolerance to be adrift, not knowing for the moment what it is about to happen [8]. In this context, it is important for the analytic pair to have the feeling of "time to waste", so that after many sessions, days, months of "unknown" the new meaning can appear.

The reverie state is a quality of what Ogden calls "dream thinking" meaning the state in which *"we view our lived experience from a multiplicity of vantage points simultaneously, which allows us to enter into a rich, nonlinlinear set of unconscious conversations with ourselves about our lived experience"* [8]. The dream-thinking allows us to do our psychological work and understand our experiences.

In this way, coming back to the question: Is countertransference what is normally understood as the analyst's reaction to the analysand's transference or can it be regarded as something more, which implies all states, thoughts, physical sensations experienced by the analyst during the session? Ogden makes the following comment: "*I believe the use of the term countertransference to refer to everything the analyst thinks and feels and experiences sensorially, obscures the simultaneity of the dialectic of oneness and twoness, of individual subjectivity and intersubjectivity that is the foundation of the psychoanalytic relationship. To say that everything the analyst is countertransference is only to make the self-evident statement that we are each*

*trapped in our own subjectivity. For the concept of countertransference to have more meaning than this, we must continually re-ground the concept of the analyst as a separate entity and the analyst as a creation of the analytic intersubjectivity. Neither of these 'poles' of the dialectic exists in pure form and our task is to make increasingly full statements about the specific nature of the relationship between the experience of subject and object, between countertransference and transference at any given moment."* [8].

"The analytic third", "reverie", "dream thinking" are some of the concepts Ogden developed in order to understand and function better in the analytic relationship. The dialectical movements between subjective and intersubjective, separate/private and together, dreamt and undreamt, ensures the alternation between transference and countertransference and leads to a new meaning of things for both analysand and analyst.

In order to show how the reverie state develops during an analytic session (at least as I understand it) I will give the example of a vignette from a case.

**A clinical example**

In a recent meeting with Mr. M, an analysand with whom I have been working for about four years, he started the session speaking about some arguments that he had with his wife the evening before.

His relationship with his wife had some problems from the beginning. At a moment in analysis, he asked me to recommend them a therapist for couple therapy and for a while they followed that therapy. Meanwhile, he continued to come to his analysis. Even if they found out many things about themselves and their couple, finally she wanted to stop it. Lately, the relationship between them has become quite tensed and he thought of separation. Recently, he has communicated this thought to his wife.

I listened to Mr. M and I realized that my feelings about all these things were quite unclear, confused, predominantly I was feeling quite scared of the possible separation, and I was surprised when he told me that he spoke with his wife about separation. Anyway, because I didn't have

any clear idea about all this I found myself quite reserved and I had an expecting attitude toward this subject.

In the session, after he told me about the discussions with his wife, he continued to speak about what he did that morning. What he did was mostly related to the routine with his small daughter: waking her up, taking her to the bathroom, washing her teeth and face, getting her dressed, having breakfast and so on.

Mr. M is 36- year- old, remarried for three years and with a two and a half-year-old daughter. He has a strong love relationship with his daughter. He is open and understandable to her mind and feelings. Every time he speaks about her, his voice is warm and soft.

At a moment, I realized that I didn't listen to him and I found myself thinking at the vacation which I had recently. That vacation was special for me, first of all because I spent my time with two dear persons, two colleagues, a woman and a man. The images which started to develop in my mind referred to the beautiful places seen by us during the trip: beautiful landscapes, very interesting monasteries, nice people. All those images weren't necessarily seen by me in a linear way; it was rather a mixture between a sensation of flying and some static, but intense moments when I admired very interesting and colorful pictures on the monasteries walls.

When I retrieved myself from this reverie, my patient was talking about the walk to kindergarten with her daughter. Every morning he takes her to the kindergarten. On their walk, he spoke different simple things with her: playing with kids, some games etc.

Again, my mind 'flew', I didn't listen to my patient and there came to my mind a moment from my childhood spent with my grandmother. It was about a beautiful summer evening, somewhere in the countryside. The sky was full of stars which sparkled in the night. My grandmother showed them to me and she said if the sky was clear and full of stars, it meant that the following day would be a good day. I admired the stars but I remained quite unsatisfied and I told her that they were too far away and finally, what are stars in fact? That moment, my grandmother showed to me some glow worms (small insects who fly and sparkle) in the air. She said that other kind of stars are around us. At that moment, as a child, her words seemed like a joke to me.

I retrieved from my reverie. My patient was talking about how he left his daughter at the kindergarten, he spoke something with the teacher and at the end he bent on his knees and said with an emphasized tone in his voice "Good bye, A". Usually he did this gesture but only that morning he used that tone.

I asked him why he used that tone and he answered: "I am thinking about what she feels when I leave. I want to transmit to her that now I am leaving but we will meet again at home, tonight."

Then, to my mind, there came again a moment from my holiday with my two colleagues. The man is an experienced analyst who taught us many things during the years. In the trip, in a discussion with him about some personal things, he reminded me about a very beautiful proverb: "Partire e un po morire". This proverb touched me a lot. For me it is a bitter-sweet proverb. It means that everytime someone leaves, he dies a little. At the same time, someone is richer with something that happened or something from the encounter with the others. Even he/she leaves, he/she will keep the connection with what happened.

For the first time in the analysis with Mr. M I had a clear idea about this subject of separation. I realized that in some way 'Partire e un po morire' means what my patient did with his daughter when he said good-bye and afterwards he left. He tried to prepare for an eventual situation in which he would not see his daughter all the time and he tried to endure this sufferance.

I told my patient about this proverb and what I think about it. Leaving means that you lose something but at the same time, you keep something inside after you leave, something which enriches you. You don't lose something/someone for good; you keep inside this connection.

Some words were then exchanged between us. He answered me: "Oh, leaving is a little bit like dying. But this means that we begin to die from our birth." I said: "Something like this, but just a little". He said: "Sometimes, somebody leaves and comes back or not; or sometimes, somebody really dies and never comes back." It was a short moment of silence during which I saw in my mind, in a vivid way, the scene with him and his daughter telling 'good-bye'. I asked him about this moment, what he feels, what he thinks about it. After a while, he said: "I think that if I

leave, I will not see A every day, every morning. I am trying to find something which can be good for all of us. I am aware that maybe she realizes something from all that happened between me and her mother… Anyway, no matter what happens, I intend to stay close to her. Finally, as you said, partire e un po morire but just un po, not for good. Over all, I don't lose A, it will just be something else than what it is now. And who knows, maybe it will be better."

I didn't say anything and there was silence until the end of session. It wasn't necessarily a 'heavy' silence, but a bitter-sweet silence. For the first time, I felt that something new was created in my mind about myself and about my patient and this experience was determined by an interpersonal interaction between me and him. I felt that a good and human exchange happened between us. In a way, I felt that my reserve and my attitude of expectation were a defense mechanism to avoid a state of sufferance. For the first time I felt that I can be emotionally open to this problem of separation.

My feeling was confirmed by him in the next session. He began to tell me about his tennis game from the previous day (the day between the sessions) when he won. He was happy and said that even if he had some clumsiness in his game, he realized how his game improved lately.

I saw this as a confirmation of a sort of a good 'game' between me and him, an exchange which created a new meaning for both of us.

**Discussions**

As I said, I consider this session as being important for both of us, me and my patient, because something was generated in our relation, something which led to a new meaning of things for us. He started to talk about his problems with his wife. Toward this subject I was feeling quite stuck and I didn't say anything. After that he started to talk about his daily routine in the relationship with his daughter.

At that moment I had a reverie about my recent vacation, a trip where I saw some beautiful places and shared some precious time with some dear friends of mine. The next reverie was about a special moment spent with my grandmother when I was a child. When I retrieved from it, I

listened to my patient talking about a special moment for him, when he said 'good-bye' to his daughter with a tone of voice different from that he usually used. I had another reverie with my colleague, an experienced analyst who told me about a beautiful proverb in one of our discussions.

Someone could say that it was just a projective identification mechanism and maybe, partially it was that. My patient put inside me something quite difficult for him (an intrapsychic content) and after quite a long period of blockage, I tried to manage it and return his intrapsychic content in a more 'digestible' way. But at the end of the session, I didn't think it was only about the intrapsychic content of my patient. As Ogden said: "*Projective identification involves the creation of unconscious narrative (symbolized both verbally and nonverbally) that involve the fantasy of evacuating a part of oneself into another person… Inextricably connected with this set of unconscious fantasies is a set of interpersonal correlates to those fantasies. The interpersonal quality of the psychological event does not follow from the unconscious fantasy; the unconscious fantasy and the interpersonal event are two aspects of a single psychological event."* ('The analytic third: Implication for psychoanalytic theory and technique') [9].

My reveries from the session were in that session with my patient, not in other sessions with other patients and neither in other sessions with the same patient. The interpersonal experience was created for me and my patient in the moment when his 'good-bye' to his daughter met my reverie about 'Portire e un po morire' and together generated a new meaning for both of us: Yes, 'Partire e un po morire' but just 'un po'.

Mr. M doesn't have to choose between staying or not with his daughter; he can find something proper for both of them. Even if he is going to separate or not, his relationship with his family does not have to be 'frozen'or split.

Also, for me, a new meaning was created in that session but I didn't realize this right at that moment; only later, in the following days and weeks. For instance, there was a correlation between the reverie with my grandmother and the reverie with my colleague saying 'Partire e un po morire'. In my childhood, I felt quite lonely and my grandmother was for me a kind of 'twin soul'. I felt that she was the only person who saw and understood me. A long time after her death, I thought that I would never

again meet someone like her. The meeting with my colleague, a very warm, understandable and emphatic person showed me again that there are other good people around me in a similar way in which my grandmother showed me other 'stars' around me. But this feeling of some proper people around me wasn't very clear in my mind but only in a vague way. What was new and interesting in this session was the fact that my patient helped me to realize that.

Another aspect which I want to emphasize with this clinical example is related to what I said at the beginning of my paper. The idea is that the analyst's reverie is different in its substance and depends on the analysand's capacity for using the object [15]. Mr. M, my patient knows to use the object, me/his mother. His reasons for coming to analysis four years ago, regarded some inhibitions, blockages determined by oedipal conflicts. I believe that I was able to have my reverie because he allowed me to dream in this way.

Whatever may happen in Mr. M's relation, I think that he will stay open emotionally toward his daughter. Also, my feelings about the problem of separation are more flexible and I am much more able to stay emotionally open in the analysis with him, too.

**The importance of the analyst's real data**

Another question which I have in my mind regarding countertransference refers to the way in which this is affected/influenced by some of the analyst's professional data: a beginner analyst, an experienced analyst, an analyst who belongs to a theoretical psychoanalytic school etc.

I want to share with you one of my personal experiences which I had some time ago when I started to write this paper. I was looking for a book in my bookcase from my office. I found it and then, in an inevitable way, I also saw and took from my bookcase other books, papers, journals, notes, etc. I began to read from different writings and the time flew very quickly. After 1-2 hours, suddenly, I felt physically very dizzy. I stopped from my writing and I tried to relax. After a while, I realized what happened and some questions came to my mind:

*- Who am I as an analyst?*
*- What is my professional identity?*
*- What kind of theoretical psychoanalytical schools are close to me? Am I freudian, winnicottian, intersubjective, relational analyst? Who am I?*

I felt this experience being very important for me, mostly because I have recently finished my psychoanalytic training and I graduated as a full analyst. And of course, it is not accidentally that I am writing this paper at this time.

Then, I began to find some answers to my questions reading "On becoming a psychoanalyst" [10] by T. H. Ogden and Glen O. Gabbard. At the beginning of the paper, they quoted Bion who said: "*It is only after you have qualified [as an analyst] that you have a chance of becoming an analyst."*

Ogden, echoing Bion wrote to me in response to my recent graduation: "*Now, your true education can begin!"* (personal communication). I think it is important for every analyst in my situation, not only for me. But what does becoming a psychoanalyst mean?

Ogden and Gabbard consider that the most important thing in one's maturation as both an analyst and an individual is to develop in time the capacity for dream thinking. Thinking/dreaming one's lived experience in the world constitutes the principal mean which helps to achieve psychological growth. Dream-thinking is the most profound form of thinking in which: "*the individual is able to transcend the limits of secondary process logic without loss of access to that form of logic."* [10]. It is about a continuous flow of our different states, feelings, emotions, thoughts, physical sensations, unconscious and conscious states, etc. Dream-thinking means our capacity for doing psychological work and creating a personal, symbolic meaning. In the absence of dreaming, we cannot learn from our lived experience. In the analysis, dream-thinking takes the form of the analyst's reverie.

From their perspective, the maturational experience of the analyst includes:
- one's own way of speaking with the patient; that means developing a voice of our own. They said: *"In the process of becoming an analyst , we must 'dream up' for ourselves from our own analyst(s) as well as past supervisors, teacher and writers we admire, while also drawing on what we have learned from*

*them. A dialectical tension exists between inventing oneself freshly, on the one hand, and creatively using one's emotional ancestry, on the other."* [10].

- presenting clinical material to a consultant; a consultant is a trusted colleague who tries to understand what another analyst does not know. This kind of sharing with somebody trusted offers the analyst the possibility to find many things about himself, his conflicts, limits, desires, anxieties, fears, shames, self-doubts, etc. All these allow him to develop his identity.
- one's analytic work as a principal medium for self-analysis. This means, as Freud said, every analysis is incomplete. In other words, transference is interminable, countertransference is interminable, conflict is interminable. Every analysis initiates an exploration of the inner life of both patient and analyst. Finally, the ending of an analysis means that the subject of the analytic work is able to think and dream his own experience.
- discovering/creating what one thinks and who one is in the experience of writing; it means that writing is a form of thinking. When somebody writes, in fact he/she thinks and creates in his/her own way. Also, somebody who writes has a reader in mind and as a result, his/her writing is influenced by the fantasy of how the reader will react to his/her paper. So, most writings involve a mixture of the two aspects;
- daring to improvise; it means that with each patient, the analyst is and behaves in a different way and what happens in an analysis is unique and unrepeatable.

These are some aspects which contribute to the analyst's maturation and create the analyst's identity.

What is the most important in becoming a psychoanalyst is *"the development of the capacity to make use of what is unique and idiosyncratic to each of them; each, when at his best, conducts himself as an analyst in a way that reflect his own analytic style; his own way of being with, and talking with, his patients; his own form of the practice of psychoanalysis."* [10].

Another question about the subject of this paper refers to the way in which the analyst's contertransference can be affected/influenced by some personal events from his/her life – for instance: marriage, divorce, the birth

of children, some medical problems, different losses, the death of somebody dear etc.

I believe that in an inevitable way, every analyst is affected by this kind of events and in some way he/she communicates all these to his/her patients. This doesn't mean that the analyst puts his/her problems on the analysand's shoulders; it is rather about the capacity of an analyst to remain available emotionally, to stay open to his/her patients, even if he/she can sometimes be overwhelmed by his/her own states. Moreover, if the analyst does it in any other way, I believe this would be hypocritical of him and harmful to patients.

I remember my own experience when I became pregnant with my daughter. All my patients reacted in one way or another, more or less expressed, verbalized, symbolized. For instance, one of my patients, a young female had a very interesting dream. She dreamt that she came to my office but my office looked very different: all the walls from the room were covered with a very soft and warm fur. She associated this with a warm and welcome uterus which keeps the baby inside well. After a few years, this young female patient became pregnant and she is now a good mother. Unfortunately, I had another young female patient who regressed very much during my absence (after I gave birth to my child I was absent from the office for almost 7 months). For this patient it was unbearable to live a strong abandon anxiety and she became very disturbing, psychotic. Finally she was hospitalized after she tried to commit suicide. I realized that during that time I couldn't sustain her states mostly because, for a while I was too caught, physically and psychologically in relationship with my baby.

Another important question is how important is it the fact that the analyst belongs to a certain theoretical psychoanalytical school?

In his paper 'The baby and the bath water' (2009), Ronald Britton [2] emphasized that the models (including the theoretical model) have advantages and disadvantages. On the one hand, thinking in models has enormous advantages for us in representing the unknown world. On the other hand, thinking in models also has disadvantages, limiting us in the

process of knowing the world. Britton quoted Wittgenstein who said this is like the flight in the 'fly bottle' of our own model.

In an analysis, there is the analysand's own model and the analyst has a theoretical model in his mind as well. Britton remembered what Bion said that the analyst's potential theoretical model should be as a container for the patient's personal model and not the other way around.

In her paper 'The anxiety of the analyst in the first interview' (2011) Mette Moller [5] does a very good review of what different writers think about the analyst's identity. She says that an analytical quality is *"the analyst's ability to withstand pressure, confusion and incomprehension, while simultaneously maintaining confidence that understanding can be found."*

Ogden and Gabbard, having the same opinion as according with Sandler, consider that each analyst develops a mixture between certain aspects of various theories and one's own subjectivity and one's own approach to analysis. They said, echoing Bion that*: "the analyst must endeavor to forget what he thinks he knows or knows 'too well' in order to be able to learn from his current experience with the patient."* [10].

**Conclusions**

In this paper I have tried to offer some answers to the questions which I had in my mind about countertransference. I used the writings of Winnicott and Ogden, their concept about 'the use of the object' and 'the mirror role of mother' (Winnicott) and 'the analytic third' and 'dream-thinking, reverie' (Ogden) in my attempt to better understand the subject of countertransference.

Echoing Ogden, I understand countertransference in the context of the intersubjective experience created by the analyst's and the analysand's subjectivity which generate 'the analytic third'. In an analysis, there is a dialectical connection between personal/private/intrapsychic moments and interpersonal/intersubjective moments. They cannot be separated, these moments do not exist in pure forms.

Also, I believe that the analyst's reverie during the sessions with the patients is different in its substance and depends on whether or not the patients have the capacity to use the object.

I believe that countertransference is affected/influenced by some significant events from the analyst's life (marriage, divorce, the birth of children, medical problems, losses, the death of somebody dear, etc). It would hypocritical and harmful to the patient if the analyst ignored all these events.

About becoming a psychoanalyst and the analyst's identity, echoing Ogden again, I believe that the most important means for an analyst as well as for an individual is his/her capacity for dream-thinking. This is the profound form of thinking and in essence it means that all our states – feelings, emotions, thoughts, physical sensations, etc. – flow continuously through us and help us do our psychological work. If this dreaming is interrupted, in that moment we need another person who can dream our interrupted dream.

Finally, becoming a psychoanalyst means that if one can think and feel in one's own way, then the true education in one's spirit and personality can begin!

**REFERENCES**

1. ABRAM, J. (1996). *The Language of Winnicott, a dictionary of Winnicott's use of words.* Karnac, London.
2. BRITTON, R. (2009). *The Baby and the Bath Water*; the paper presented at 46th Congress of IPA, Chicago.
3. FREUD, S. (1912). Recommandations to Physicians Practicing Psychoanalysis. *SE*, vol 12.
4. FREUD, S. (1915). The Unconscious . *SE*, vol 14.
5. MOLLER, M. (2011). *The Anxiety of the Analyst in the First Interview*. The paper presented at 24th Annual Conference of EPF to Copenhagen.
6. OGDEN, T.H. (1994). The Analytic Third: Working with Intersubjective Clinical Facts. *Int. J. Psychoanal* 75:3-19.
7. OGDEN, T.H. (1996). Reconsidering Three Aspects of Psychoanalytic Technique. *Int. J. Psychoanal*, 77:883-899.
8. OGDEN, T.H. (1997). Reverie and Interpretation in *Reverie and Interpretation,* Sensing Something Human, Karnac Books, London.

9. OGDEN, T.H. (2004). The Analytic Third: Implication for Psychoanalytic Theory and Technique, *Psychoanal Quarterley*, 73:167-195.
10. OGDEN, T.H., GABBARD, G.O. (2009). On Becoming a psychoanalyst. *Int. J. Psychoanal*, 90: 311-327.
11. OGDEN, T.H. (2010). On Three Forms of Thinking: Magical Thinking, Dream Thinking, Transformative Thinking. *Psychoanal. Quarterly*, 2.
12. WINNICOTT, D.W. (1960). The Relationship of a Mother to her Baby at the Beginning, in *The Family and Individual Development*, Routledge, London and New York.
13. WINNICOTT, D.W. (1967). Mirror- role of Mother and Family in *Child Development, in Playing and reality,* Routledge, London and New-York.
14. WINNICOTT, D.W. (1968). The Use of the Object and Relation through Identification, in *Playing and Reality*, Routledge, London and New-York.

# THE RULE OF ABSTINENCE AND COUNTERTRANSFERENCE

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**Résumé**

*Mon article met en discussion la relation entre la règle de l'abstinence et le contretransfert, relation qui se trouve plutôt implicitement qu'explicitement dans les études de spécialité. J'y distingue trois moments: l'exclusion du contre-transfert à travers la sollicitation de l'abstinence comme règle ; la restriction de la règle de l'abstinence aux troubles névrotiques et l'accent mis sur l'importance de l'observation et de l'expression du contre-transfert pour la pathologie psychotique et la pathologie borderline; l'exclusion de la règle de l'abstinence et l'affirmation, comme substitut, du principe de la « gratification optimale » qui promeut l'expression du contre-transfert, principe valable même dans le cas des troubles névrotiques.*
*Je propose, mettant l'accent sur les points de vue extrêmes, unilatérales : « le principe de la facilitation optimale de l'analyse » en tant qu'alternative qui surpasse leur attitude limitée dans le cadre d'une synthèse équilibrée.*

**Abstract**

*My contribution debates the relationship between the rule of abstinence and countertransference, existing much more implicitly than explicitly in the specialized studies. I discern three moments: exclusion of countertransference by the demand of abstinence as a rule; restraining the abstinence rule to neurotic disorders and emphasizing the importance of noticing and expressing countertransference for the psychotic pathology and borderline; exclusion of the rule of abstinence and the assertion, as a substitute, of the "optimal gratification" principle, which promotes the expression of countertransference, a valid principle for the neurotic disorders too.*
*By pointing out the one-sided extreme points of view, I put forward: "the principle of the optimal facilitation of the analysis" as an alternative to overcome one-sided attitudes inside a balanced synthesis.*

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**Mots-clés:** abstinence, contre-transfert, principe de la"gratification optimale"

**Key-words:** abstinence, countertransference, "optimal gratification" principle

Today's contribution has as a starting point a beneficial event in the life of S.R.P., namely the elaboration of the necessary papers in order to become a provisional society inside the International Psychoanalytical Association (I.P.A.). In the meantime, this cycle ended with a success. The controversy, it's true that just for a short period of time and in fact almost undiscussed it yet was provoked by "the rule of abstinence" included into the Ethical Code. With no difficulties, we agreed on the contents of the paragraph consisting of two regulations that I will briefly mention as follows: a) the restraint regarding the social contacts with analysands, outside the psychoanalytical frame; b) the interdiction "of any kind of sexual relationship with patients and candidates" during the analysis or the supervision. The disagreement appeared regarding keeping the classical syntagm "the rule of abstinence". Those pleading for giving it up referred to its absence from the ethical code of I.P.A., while the colleagues who were in favour of maintaining it referred to its presence in the ethical codes of other European psychoanalytical societies of long tradition. We couldn't reach any agreement due to insufficient time and the final solution was obtained as a result of taking the decision to express everybody's point of view using the voting system.

I still regret the fact that we couldn't go on with our debate, which I considered extremely interesting and useful. As far as I am concerned, I must admit that I have never had doubts until then, taking the rule of abstinence as granted and applying it in my own way, sometimes rigorously and other times more flexibly, according to the psychoanalytical relationship with each and every analysand. That is why, after the S.R.P. meeting dedicated to the ethical code, I have started to read studies of contemporary psychoanalysis with the intention to deeply think about it, starting from new elements regarding the issue with an intention to relaunch the debate started at S.R.P. on the occasion of the annual conference.

The run over, an inevitably lacunary one, through the articles dedicated to the topic of abstinence, over 300 in PEP-WEB, made me come to two surprising conclusions, each in its own way. First of all, the debates regarding the issue of the rule of abstinence are of considerable amplitude, implying different points of view which are remarkably well outlined. Then, the implicit correlation of this already mentioned rule with countertransference. I will now try to present some significant orientations and explain the influence of the rule of abstinence on the acceptance and use of countertransference.

One of the first findings was that all articles dedicated to the topic we deal with, consider as necessary a reevaluation of the rule of abstinence, even those pleading for maintaining it in its classical shape. Freud defined it quite clearly in two of the texts dedicated to the psychoanalytical techniques. In "Observations on Transference-Love" (1915), Freud states that: "the cure must be done in abstinence" [2]. Four years later, in "Ways of psychoanalytic therapy" he had a more balanced point of view: "The analytical cure must be done as much as possible in terms of abstinence." [2]. And besides that, abstinence is called a principle (Grundsatz) and not a rule (Vorschrift), although in another technical work published in 1937: "Analysis terminable and interminable", Freud used this last term. So, what is abstinence for Freud, is it a principle or a rule?

Although it seems an insignificant difference, several psychoanalysts, among whom Richard P. Fox in the article "The Principle of Abstinence Reconsidered" [1], considers that the change of abstinence into a principle, as it was thought by Freud, meaning a selective restraint of gratifications, but not a complete elimination of them, which according to Freud would be impossible in case of an ill person, into a rule that would mean the very unselective suppression of any gratification had negative effects in the development of psychoanalysis. The following vignette suggested by the author illustrates the counterproductive effects of applying "abstinence" as a rule avoiding any kind of gratification no matter the circumstances connected to the analysis.

In the initial stage of the analysis, the woman patient asks her psychoanalyst if she can use his consulting room's toilet. The negative answer is justified by the fact that the consulting room, being located in the

very house of the psychoanalyst, had no separate toilet. It must be specified that the patient was coming by her own car, from quite a distance and she considered quite uncomfortable to use the toilet of the first gas-station, on her way back home after every therapy session. After this denial, the psychoanalyst tried to point out the meaning of the patient's reaction to the imposed frustration. There followed a struggle of several weeks when the patient reiterated her demand and the psychoanalyst his refusal and then several months of stagnation. Finally, the patient decided to give up the analysis. The analyst's error was not to discern the legitimacy of the patient's demand and the non functionality of his consulting room, applying the abstinence as an absolute rule to an inadequate situation, when even if there was a shifting of a growing intimacy desire upon the analyst, the reality elements hindered her analysis in that moment in those conditions.

Regarding countertransference, psychoanalysis is now in a stage when the rule of abstinence forbids countertransference as a feeling and especially as a manifestation. According to Robert Hinshelwood, Freud contributed to the neglect of countertransference for many years, considering it as "the psychoanalyst's neurotical transfer" which "must be eliminated" by means of self-control [4]. The metaphors by means of which the founder of the psychoanalysis illustrates the optimal attitude of the analyst, implant the rule of abstinence to the detriment of countertransference: the white screen, the cold look of the surgeon, and even the telephone receiver. A retrospective testimony of James McLaughlin describes the atmosphere regarding the negative meaning attributed to countertransference in the 40s, when the author was during his training period, today a trainer psychoanalyst and a supervisor. "Find out what the patient wants in order not to give it to him/her" was the slogan of that time. The gratification of the wishes expressed by any side was considered "a serious error of technique proving a countertransference, which meant the imperative signal that more analysis is needed" [6].

Another moment and at the same time another orientation within the parallel and correlated development of the rule of abstinence and countertransference is represented by the reduction of the validity for the

rule of abstinence, just in case of neurotic disorders and the acknowledgment of the importance to notice and express countertransference while psychoanalytically approaching the severe psychotic and borderline pathology. Robert Hausner dedicates a synthetic article to this very moment. I quote: "During the neurotic disorder, frustration is an essential element catalyzing the development of the experimentator's ego during the one hour session which doesn't cancel the functions of the observing ego, maintaining a permanent perspective upon the analyst's person." [3]. For the psychotic or borderline disorders, the typical frustration characteristic to the psychoanalytical method, because of a weaker ego, acts differently, because not being accepted for the analysis is perceived as not being accepted in the early childhood. According to Winnicott, if in neurotic disorders the past comes to the consulting room, in pregenital disorders the present goes into the past, *becoming* the past. In this latter case, the need to receive gratification from the analyst as a real person for the frustrated needs inside the primary diadic relationship is important. And from here, alterations of technique regarding the necessity to take into consideration the gratification of this need are requested.

In order to illustrate it, I will use a vignette offered by John Lindon [5]. The patient, a young delinquent, 15 years old, drug user, is taken for a therapy immediately after being released from prison, on a judiciary recommendation. During the 14$^{th}$ week of treatment, he is abandoned by his girlfriend, which leads to a suicidal attempt. Lindon puts him in hospital, where the patient regresses even more. Lindon decides to go there daily during the hospitalization period, which takes several months. After being released from hospital, the rhythm of the therapy sessions is maintained for 6 more weeks. Then the number of sessions is reduced to 6 per week, and afterwards to 5. The 11 months of intensive psychoanalytical therapy have been coined by Lindon "feeding". The psychoanalyst answered to the patient's role solicitation, offering him care, warmth and paying him a lot of attention. Anna Freud to whom the case had been presented during her visit to Los Angeles estimated that this analytical "feeding" of Bob, helped him not only to overcome the psychotic fragmented condition, but also to develop a new stable psychic structure, which persisted after the treatment came to an end.

The third position, a radical one, regarding the rule of abstinence claims that this is not only unnecessary from the point of view of the analysis facilitation, stated by Freud himself, but also damaging, because it blocks and prolongs the analysis, leaving vast areas of the psychic outside the analysis. The argumentation of John Lindon, who seemed to be one of the most coherent representatives of this point of view is extensive, but I will refer to it briefly, because, for the time provided, it is more important what Lindon proposed in order to replace the rule of abstinence. Essentially, the American psychoanalyst asserts that even the most rigorous classic analysis offers a certain number of non-assumed and non-thematic gratifications such as: empathy, protection, communication as well as the psychic reorganization ensuring the liberation from the clichés of the past.

As solutions to the shortcomings of the rule of abstinence, that blocks the awareness and expression of countertransference, Lindon proposes its replacement with the rule of "the optimal gratification" through which I translate two terms: "gratification" and "provision." I am goig to presenttwo of Lindon's vignettes which will make clear that he refers to an enactment countertransference. It is crucial to mention the fact that Lindon considers that the new rule can be applied successfully not only in the case of severe pathologies, but also in the case of neurotic disorders.

In his vision, the main argument is that the rule of the optimal gratification facilitates the analysis much better than the rule of abstinence. In Lindon's conception, as he points out clearly, the aim of the analysis is not to leave the patient's psychic organization unmodified, but to fulfill his/her needs of development which have already been activated, to favor the understanding and the change of his/her subjective experiences. Before presenting the two already announced vignettes, I couldn't ignore the fact that Lindon, besides the clinical and logical arguments, also invokes the authority arguments. So, Winnicott confessed to him that he had left the analytical session to last as long as the patient needed, sometimes even three hours and a half.

The first vignette, illustrating the advantages of Lindon's method in case of neurotic personalities, refers to a certain moment from the training analysis of a young psychiatrist, already in the third year, who talks about

a dream where he was all alone and isolated at the South Pole. Both of them, the analysand and the analyst failed to understand the dream, although the former provided associations. During the next session, the young psychiatrist is almost trying to ask a question, but he gives up. Finally, it resulted that the analysand wished to ask the analyst to read a psychiatric evaluation, which he had made on the demand of a tribunal. The reason was a certain incertitude. The reason he gave up the question was that the analysand knew that he "shouldn't" ask for the analyst's opinion. Lindon reads the assessment, expresses his appreciation and adds a few recommendations. The analysand's association to the analyst's acting was that, in his childhood, he didn't ever succeed in determining his father to pay attention to his school activity and that is why he felt alone in this world. The dream became intelligible as the expression of the analysand's wish to ask for the psychoanalyst's opinion about his report and the terror not to be refused and to feel, like in his childhood, completely isolated.

"If I were not preoccupied to gratify certain instinctual derivatives", Lindon comments upon his countertransference manifestation, "I wouldn't have read the assessment and then a traumatic reenactment of the scenario lived with his father in his childhood would have taken place." [5].

The second vignette indicates the limits of the optimal gratification rule. It's about the expression of countertransference when the analyst hadn't first explored the direction of the particular transference of his act. So it's about a non-optimal gratification, which instead of facilitating the analysis, ends up disturbing it.

Before his holiday, Lindon offers the patient his phone number from a foreign country, where he could be reached if in need. The reaction of the patient was very strong and negative. He considered the proposition as a narcissistic injury, as if he were a baby who couldn't manage by himself. Lindon considers that gratification would be optimal in this case if he had asked before if the phone number was necessary during the holiday period. The reason of the countertransference enactment was a feeling of culpability felt by the analyst who was "leaving" his patient just a few months after the beginning of the analysis, while he was still having panic attacks. But the patient taught him that he had a level of psychic organization higher than the one supposed by the analyst.

Lindon also answers the question that one of the readers of his studies would have asked: the expression to consent to a woman patient's need to have a sexual relationship with the analyst as a means of facilitating her development towards her feminity, makes the object of the rule of the optimal gratification? In such cases, gratification wouldn't be optimal for the analyst, affecting his integrity. That is why Lindon refused such demands, communicating the reason explicitly. It is very interesting that Lindon found benefits for the analysis even in the very application of the rule of abstinence, mainly, noticing the way in which the refusal of the analyst is received and finding out the reason of the sexual demand.

If the goal of any regulation in psychoanalysis, technical or ethical, consists in facilitating the analysis, then the introduction, by Lindon, of the optimal gratification rule means just substituting a kind of unilaterality for another. No matter how optimal the gratification would be, it couldn't be an absolute but a selective one, as well as abstinence, which means that it couldn't give the contents of a new rule, because it would face the same objections as the rule of abstinence, meaning the inevitable interpenetration with frustration. If the facilitation of the analysis supposes frustration and gratification too, dosed in a different way according to many factors, then none of these two rules would justify their existence and neither the rule of abstinence, which is a sacred vestige of the history of psychoanalysis, nor the rule of gratification, or any other similar rules.

In case we discuss on the level of principles, of general recommendations, then the principle of abstinence, according to Freud, selectively, without excluding gratification, as well as the optimal gratification principle proposed by Lindon, which supposes frustration too, could become the object of a legitimate option of the patient's pathology or the theoretical orientation of the psychoanalyst. As far as I'm concerned, in order to avoid the excessive polarizations and the sterile disputes, I would propose as a synthesis solution: ***the principle of the optimal facilitation of the analysis.***

**REFERENCES**

1. FOX, R. P. (1984) The Principle of Abstinence Reconsidered, *The International Review of Psycholo-Analysis*, no.11, p. 227.
2. FREUD, S. (1915). *Scriften zur Behandlungstechnik,* Studienansgabe, Band 11, S. Fischer, 1989.
3. HAUSNER, R. S. (1994) "Analytic Abstinence and Preoedipal Disturbance", *The Psychoanalytic Study of the Child*, no. 49:190.
4. HINSHELWOOD, R. D. (1999) Countertransference, *The International Journal of Psychoanalysis*, 80:797.
5. LINDON, J. A. (1994). Gratification and Provision in Psychoanalysis: Should We Get Rid of "The Rule of Abstinence?", *Psychoanalytic Dialogues*, 4:560.
6. Mc.LAUGHLIN, J. T. (2000) "The Problem and Place of Physical Contact in Analytic Work: Some Reflection on Handholding in the Analytic Situation", *Psychoanalytic Inquiry,* 20:65.

# Recherche scientifique en psychanalyse

# Scientific research in psychoanalysis

# IS IT POSSIBLE TO MEASURE COUNTERTRANSFERENCE?

*Horst Kächele*[8] *& Ingrid Erhardt*[9]

**Résumé**

*La recherche empirique du processus thérapeutique a longtemps évité - justement – même d'essayer à mesurer le contretransfert bien que cette dimension du processus psychanalytique ait pris de l'élan les dernières décennies. Notre article met en évidence les divers efforts entrepris dans la direction de l'approche d'une telle méthodologie de mesure d'un concept si flou. La distinction entre les patterns habituels de contre-transfert et les réactions affectives situationnelles semble être la plus utile modalité d'approche de ce sujet. On présentera et on discutera des études empiriques récentes et des mesures relatives au contre-transfert.*

**Mots-clés:** recherche empirique, contre-transfert, pattern, mesure du contre-transfert

**Abstract**

*Empirical research on the treatment process has long time - for good reasons - avoided to even try to measure countertransference, although this dimension of the psychoanalytic work has gained in momentum over the last decades.*
*Our paper reports on various efforts of how to approach such a methodology for measuring such an elusive concept. The distinction between habitual patterns of countertransference and situational affective reactions seems most likely a helpful way to approach the topic. Recent empirical research and measures on countertransference will be presented and discussed.*

**Key words:** empirical research, countertransference, pattern, measures on countertransference

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"Freud viewed countertransference, even when he first discovered it [9], as connected with the patient's transference in a dynamic way. It "arises in him [the physician] as a result of the patient's influence on his unconscious feelings" [9]. Freud emphasizes that "no psychoanalyst goes further than his own complexes and internal resistances permit" [9]. Thus it is necessary for the analyst to undergo a training analysis in order to be freed of his "blind spots."

The fact that the analyst's ""personal equation"" [10], would still remain even after the influence of countertransference had been mastered (i.e., ideally, eliminated) was regretfully accepted as inevitable. Freud hoped that training analysis would lead to such a far-reaching balancing of the personal equation that satisfactory agreement would one day be achieved among analysts" [10].

In this lecture we reappraise how this elusive technical concept became a topic in systematic treatment research – a scientific activity that started around the fifties in the centers of psychoanalytic empirical research.

The first attempts to catch the phenomenon of countertransference made use of the clinicians´ capacity to identify countertransference issues in clinical materials. The simple strategy consisted of using rating scales that would list a number of technical concepts like transference, resistance, and countertransference to be qualified on a non-parametric dimension ranging from zero to four. This rating could be provided by external observers like in the experimental study by Bellak & Smith [4] or even by treating therapists themselves like in the study of Luborsky´s research group in Philadelphia. In this study, four therapists conducting psychoanalytic treatments over a long period of time had to weekly asses the degree of expression of such concepts on the Therapy Session Sheet [11]. Besides qualifying the patient´s capacities as reflective, receptive, anxious, depressive, hostile, the degree of transference in terms of being either manifest or latent, positive and negative, a score had to be given for the degree of resistance, the number of dreams, the kind of interpretations offered to the analysand and last but not least the analysts had to qualify their own emotional reaction to the material of the past week.

One may wonder how easy or difficult was it for the participating analysts to simply summarize in one score per week an ongoing self-reflective activity which would entail the careful differentiation of their own emotional state of mind from the assumed induced countertransference reaction. No wonder that in the same year this study was published; Singer & Luborsky [19] summarized the unsatisfying state of the art of catching the butterfly of countertransference by formal research methods.

The Ulm group on process research started with a similar kind of task. In the early seventies, when Dr. Thomä provided his first tape recorded case, Christian Y, a second analyst, Dr. Rosenkötter, was listening to the tape recordings and made an analogous judgment of the materials as the analyst did. Analyzing the data set led to rather disappointing findings. A factor analysis of the data sets showed clearly that both, the treating analyst and the observing analyst produced a single factor solution: the sessions were either good or bad in terms of transference and countertransference. The interdependence of both clinical concepts was quite substantial. To take the findings as a corroboration of the clinical nexus between both concepts was too easy an escape. One of our early findings consisted in the observation that the treating analyst sometimes tended to produce rather lengthy interventions that the observing analyst did qualify as a sign of countertransference due to the patient´s robust resistance to move on. At a later state of our research, when we had developed formal measures of verbal activity using computer technology we could show that indeed, the tendency of being too verbose marked the sessions that were judged as difficult periods in the analysis [16].

In another study, where we investigated the initial interviews of five therapists, we identified one therapist who initiated every second intervention by saying "but". Most likely this junior therapist should have talked to his supervisor!

Maybe these explorations were too simple-minded to get the field closer to the phenomenon. Luckily, Prof. Beckmann from the Department of Psychosomatics in Giessen presented a true experimental study on the issue of countertransference propensities in 1974.

Applying a psychoanalytically informed, but psychometrically sound questionaire, the Giessen-Test – which had been developed by Prof. Richter and himself – he studied a group of psychoanalytic candidates who observed many patients in a psychoanalytic initial interview through a one-way-window. The patients and the candidates had to fill out the same questionaire about themselves and the candidates had to describe all patients with the instrument. Applying a lot of complicated statistics he could finally present solid findings. The candidates who displayed higher levels of depressive features overrated the degree of hysterical features in the patients; vice versa, the candidates who qualified with higher levels of hysterical features overrated the degree of depressive features in the patients; and the candidates with higher levels of obsessiveness overrated the degree of obsessiveness in the patients [3].

Repeating the experiments at a later stage of the candidates' training, the degree of overrating was conserably reduced, but the impact of personal dispositions had not disappeared [2]. A nice proof of Freud's idea of 'personal equation' was thus demonstrated by good experimental work.

Furthermore, by this study it became clear that it would be sensible to conceive countertransference in terms of a state-trait model. As individuals with a fairly stable personality make-up, each of us shares a certain propensity to bring to the clinical encounter certain personality features that most likely tinge our way of looking at clinical issues: this would be the trait aspect of every´s countertransference. In addition to it, concrete clinical instances might lead to more or less actualizations of this propensity.

Now what do we know so far from formal empirical research. It will not come as a surprise to you that most of the research has not studied psychoanalytic treatments per se but as in all subjects mainly psychodynamic psychotherapies. Luckily, a recent review on the state of the art was provided by Hayes et al. [13].

They review three metaanalyses; the first focuses on the impact of countertransference on the outcome of treatment, the second focuses on the issue whether the capacity to manage countertransference reduces the

manifestations of countertrensference feelings and the third rises the question whether managing countertransference improves the outcome.

Metaanalysis: 10 Studies with N = 769 Patients
Metaanalysis: 11 Studies with N = 1065 Patients
Metaanalysis: 7 Studies with N = 478 Patients

The Instrument used by all included studies was the Countertransference Factors Inventory CFI or, respectively, with one of the two abbreviated versions: the CFI-R or the CFI-D. The CFI consists of 50 items and captures therapists' features that describe the handling of countertransference, respectively the functioning of a therapist in the therapeutic situation in relation to countertransference management. The CFI-R contains 27 items from the CFI and the CFI-D consists of 21 items which are specific to the therapists functioning during psychotherapy. All three versions of this measure contain five sub-scales: self-insight (refers to the therapist's capacity to reflect their own state of mind etc.), self-integration (focuses on therapists' healthy charactere structure), anxiety management (captures therapists management and coping with anxiety), empathy (refers to the ability to partially identify with the patient), and conceptuality ability (which reflects therapists' ability to integrate theory and understand the actual therapeutic situation). The CFI may be used as a self-rating instrument or can be applied by a rater f.e. the supervisor. What follows is a simplified presentation of the findings of the meta-analyses:

CT-responses show a significant negative, yet numerically small correlation with treatment outcome (r = -.16, p = .002, 95% CI [-.26, -.06]) (Tab.1)

**Tab. 1 Studies on the relationship between countertransference and outcome**

| Authors | Sample | Design | Setting | r |
|---|---|---|---|---|
| Mohr, Gelso & Hill (2005) | N = 88 P, 27 Tª | orrelational | Lab | -0.04 |

| | | | | |
|---|---|---|---|---|
| Myers & Hayes (2006) | N = 224 | xperimental | Lab | -0.04 |
| Cutler (1958) | N = 5, 2 T[a] | Correlational | Field | -0.24 |
| Rosenberger & Hayes (2002b) | N = 1 P, 1 T | correlational | Field | -0.06 |
| Ligiero & Gelso (2002) | N = 50[a] | correlational | Field | -0.32** |
| Hayes, Riker & Ingram (1997) | N = 20 P, 20 T[a] | correlational | Field | -0.33*. |
| Hayes, Yeh, & Eisenberg (2007) | N = 69 P, 69 T | correlational | Field | -0.03 |
| Nutt, Williams & Fauth (2005) | N = 18 P, 18 T | correlational | Lab | -0.37 |
| Yeh & Hayes (2010) | N = 116 | experimental | Lab | -0.38*** |
| Bandura, Lipsher & Miller (1960) | N = 12 P, 17 T | correlational | Field | -0.53* |

[a] Therapists were trainees [or students] in psychotherapy training]; P = Patient, T = Therapist, S = Supervisor; $p \leq .05$*; $p \leq .01$**; $p \leq .001$*** (1-tailed)

The factors of countertransference managment play a little or no role in the mitigation of countertransference reactions ($r = -.14$, $p = .10$, 95% CI [-.30, 0.3]) (Tab.2)

**Tab. 2 Studies on the relationship between countertransference management and countertransference**

| Autoren | Stichprobe | Design | Setting | r |
|---|---|---|---|---|
| Gelso, Fassinger, Gomez & Latts (1995) | N = 68 [a] | experimental | Lab | -0.04 |
| Robbins & Jolkovski (1987) | N = 58 [a] | correlational | Lab | -0.04 |
| Forester (2001) | N = 96 | correlational | Field | -0.10 |
| Kholocci (2007) | N = 203 | correlational | Field | -0.15 |
| Hayes, Riker & Ingram (1997) | N = 20, 20 T[a] | correlational | Field | -0.18 |

| | | | | |
|---|---|---|---|---|
| Peabody & Gelso (1982) | N = 20 P, 20 Tª | correlational | Field | -0.24 |
| Nutt Willians, Hurley, & O'Brian, Degregorio (2003) | N = 301 | correlational | Field | 0.29* |
| Nutt Willians & Fauth (2005) | N = 18 P, 18 T | correlational | Lab | -0.43*** |
| Latt & Gelso (1995) | N = 47ª | correlational | Lab | -0.45*** |
| Hofsess & Tracey (2010) | N = 35 Tª, 12 S | correlational | Field | -0.57*** |
| Friedmann & Gelso (2000) | N = 149 | correlational | Field | -0.59*** |

p ≤ .05*; p ≤ .01**; p ≤ .001*** (1-tailed)

Successful managment of countertransference correlates significantly with better treatment outcome (r = .56, p = .000, 95% CI [.40, .73]) (Tab. 3)

**Tab. 3 Studies on the relationship between zwischen CT-Management and Outcome**

| Authors | Sample | Design | Setting | r |
|---|---|---|---|---|
| Rosenberger & Hayes (2002b) | N = 1 P, 1 T | corr. | Field | 0.38*** |
| Fauth & Williams (2005) | N = 17 P, 17 T ª | corr. | Lab | 0.17*** |
| Nutt Williams & Fauth (2005) | N = 18 P, 18 T | corr. | Lab | 0.18 |
| Gelso, LAtts, Gomes & Fassinger (2002) | N = 63 P, 32 Tª | corr. | Field | 0.39** |
| Peabody & Gelso (1982) | N = 20 P, 20 Tª | corr. | Lab | 0.42* |
| Van Wagoner, Gelso, Hayes & Diemer (1991) | N = 122 | experim. | Lab | 0.55*** |
| Latts (1996) | N = 77 P, 77 Tª | corr. | Field | 0.89*** |

p ≤ .05*; p ≤ .01**; p ≤ .001*** (1-tailed)

The handling and respectively the managment of CT depend mainly on the therapists' personal qualities. If they show certain features (f.e. self-awareness) or are able to implement certain exercises (f.e. meditation) they are more likely to handle their countertransference. However, certain characteristics of patients play also a role. Some patients (f.e. borderline patients) generate countertransference reactions that are more likely to be difficult to handle. Therefore, the demonstrated negative correlation between CT and the outcome could be mediated by patients' features.

It is quite clear – even in the realm of formal treatment research – that acting out countertransference feelings is not fertile for the treatment outcome. The capacity to manage one's countertransference responses in a reflective way supports a positive result of the therapeutic efforts. The empirical confirmation of the countertransference-interaction hypothesis as stated by Gelso & Hayes [12], which states that the patient and therapist variable contributes to countertransference, shows that specific patient variables interact with certain conflicts of the therapist. Thus, the key for therapeutic usefulness of countertransference resides in the connection of theory and personal knowledge [18].

This idea of a form of habitual countertransferences was recently taken up by Drew Westen´s research group in Atlanta. The paper by Betan and Westen [6] starts with a quite typical clinical illustration where any experienced clinicians will recognize the countertransference issues involved:

"From the start, the patient criticized his therapist's therapeutic style, choice of words, and efforts to explore his reactions. Most times, the therapist ventured to speak, her words triggered the patient's angry outbursts. He demanded the therapist repeat verbatim the words he wanted to hear, and it seemed he could not tolerate anything but perfect and absolute mirroring. Paraphrasing, using synonyms, pointing out the controlling quality of his demands brought an onslaught of criticism of the therapist's personhood with accusations that the therapist was inhumane, disingenuous, and even nonhuman. The patient's efforts to dehumanize and annihilate the therapist intensified during periods of consistent attendance.

Normally, however, the patient arrived 30 min late if he arrived at all. The interpretations of Mario's need to control the interaction and his fears of difference, along with the attempts to articulate the therapist's understanding of the links between Mario's early experiences and presentation in the treatment, sometimes seemed to quiet his anger and promote collaboration. However, at other times, he experienced these interventions as the therapist's withdrawal and abandonment, intensifying his anxiety and rage.

In the face of ongoing interpersonal assaults, it became increasingly difficult for the therapist to think her own thoughts. She felt stilted and stifled, as well as angry, in response to what she experienced as Mario's effort to control her. At each appointment, waiting to see if Mario would arrive, the therapist hoped he would miss, dreaded that he would attend, and worried about his well-being" [6].

In this paper, Betan and Westen point out that in the research related to countertransference, a series of analogue studies have defined countertransference as the therapist's reactions to a patient that are based solely on the therapist's unresolved conflict and, as a result, have operationalized countertransference in terms of the therapist's avoiding behaviors (i.e., disapproval, silence, ignoring, mislabeling, and changing the topic). These studies focus on negative countertransference and are limited to what countertransference tells us about the therapists. Furthermore, the studies do not investigate the specific internal emotional responses or thoughts associated with countertransference reactions.

In order to catch the specifics of the therapists´ involvement they have designed the Countertransference Questionnaire [5] in order to assess the range of cognitive, affective, and behavioral responses therapists have to their patients. They claim that this is the only broad measure of countertransference with ecological validity in its application to directly studying clinicians' countertransference reactions in treating patients.

The Countertransference Questionnaire is an empirically valid and reliable measure of countertransference responses that can be applied to a range of diagnostic and clinical populations. The developers of this instrument were especially interested in studying the relationship between patients' personality pathology and countertransference reactions in order

to test clinically derived hypotheses that have never been put to empirical investigation.

To render some concrete feelings about how an instrument works, we report some details on the most salient factors that Betan and Westen have identified:

Factor 1, Overwhelmed/Disorganized (coefficient alpha = .90), involves a desire to avoid or flee the patient and strong negative feelings including dread, repulsion, fand resentment.

I feel resentful working with him/her .72
I wish I had never taken him/her on as a patient .71
When checking phone messages, I feel anxiety or dread that there will be one from him/her .69
S/he frightens me .67
I feel used or manipulated by him/her .62
I return his/her phone calls less promptly than I do with my other patients .61
I call him/her between sessions more than my other patients .60
I think or fantasize about ending the treatment .59
I feel mistreated or abused by him/her .55
I feel pushed to set very firm limits with him/her .54
I feel angry at him/her .52
I feel repulsed by him/her .50

Factor 2, Helpless/Inadequate (coefficient alpha=.88), was marked by items capturing feelings of inadequacy, incompetence, hopelessness, and anxiety.

I feel I am failing to help him/her or I worry that I won't be able to help him/her .84
I feel incompetent or inadequate working with him/her .80
I feel hopeless working with him/her .78
I think s/he might do better with another therapist or in a different kind of therapy .67

I feel overwhelmed by his/her needs .62
I feel less successful helping him/her than other patients .62
I feel anxious working with him/her .61
I feel confused in sessions with him/her .52

Factor 3, Positive (coefficient alpha = .86), characterizes the experience of a positive working alliance and close connection with the patient.

I look forward to sessions with him/her .69
S/he is one of my favorite patients .67
I like him/her very much .67
I find it exciting working with him/her .58
I am very hopeful about the gains s/he is making or will likely make in treatment .52
I have trouble relating to the feelings s/he expresses .48
If s/he were not my patient, I could imagine being friends with him/her .44
I feel like understanding him/her .43
I feel pleased or satisfied after sessions with him/her .43

Factor 4, Special/Overinvolved (coefficient alpha = .75), indicates a sense of the patient as a special relative to other patients, and ''soft signs'' of problems maintaining boundaries, including self-disclosure, ending sessions on time, and feeling guilty, responsible, or overly concerned about the patient.

I disclose my feelings with him/her more than with other patients .64
I self-disclose more about my personal life with him/her than with my other patients .64
I do things, or go the extra mile, for him/her in a way that I don't do for other patients .52
I feel guilty when s/he is distress or deteriorates, as if I must be somehow responsible .39
I end sessions overtime with him/her more than with my other patients .39

The factor structure offers a complex portrait of countertransference processes that highlight the nuances of therapists' reactions toward their patients. The dimensions are distinct and go beyond the cursory divisions between ''positive'' and ''negative'' countertransference. For example, they identified distinct experiences of negative countertransference – i.e., feeling overwhelmed and disorganized, helpless and inadequate, disengaged, or mistreated with a patient.

Similarly, the sexualized, special/overinvolved, and parental/protective factors all suggest affiliation or closeness, but with distinct clinical roots and implications for treatment.

In addition, to illustrate the potential clinical and empirical uses of the instrument, they report on prototypes of the "average expectable" countertransference responses to patients with a personality disorder. Delineating the specific content and domains of countertransference may help therapists understand and anticipate their reactions toward patients, as well as further clarify how countertransference influences clinical work and can have a diagnostic value.

Although the clinical literature is rich in cogent descriptions of therapist reactions, empirical investigation of countertransference as it occurs in clinical practice avoids the subjectivity of clinical observation that is generally based on a single author's clinical experience with a limited number of cases. The Countertransference Questionnaire, used with a practice network approach, allowed them to pool the experience of dozens of clinicians and thereby identify common patterns of countertransference reactions that are not readily apparent to an individual observer or from even an in-depth review of the clinical literature.

Delineating the specific domains of countertransference may aid therapists in increasing awareness of and management of the myriad reactions we have toward patients.

What kinds of use will such research instrumentation have for training of younger, less experienced therapists? Most likely it may help the unexperienced, the novice, to identify his or her emotional responses to difficult-to-treat patients. It could be used in supervision, directing the attention to the plethora of potential responses.

Returning to their clinical example, they state:

"Mario's therapist is beset by feelings similar to those captured in our prototype of countertransference responses to narcissistic patients. Frustrated with and resentful of Mario's inability to acknowledge the therapist as a separate being, the therapist found herself withdrawing: she consciously wished Mario would leave treatment, lamenting that she ever took him on as a patient and feeling relieved when he would miss a session. In the moments she could not think her own thoughts, she had disengaged from the patient and the treatment. In the moments she could not bring herself to repeat Mario's words, she had rejected his mirroring transference needs, being unable to tolerate her becoming merely an "impersonal function" [17] that parrots the patient's words to confirm his sense of himself [6].

This report on research on countertransference cannot end till we have returned to the microscopic level of therapeutic interaction. The New York research psychoanalyst Hartvig Dahl and his coworkers wrote about "countertransference examples of the syntactic expression of warded-off contents"[7]. There are indeed myriad possibilities about how the unconcious mind with its emotional and cognitive components can impact on the production of spoken language especially ('parole' in de Saussure sense). In his seminal work on the „Psychopathology of everyday life" [8] gave a beautiful example that can lead our attention to the smaller examples of countertransference responses. One of my beloved examples of such a small countertransference incident is the following: A well know therapist had offered to a patient that she could call him when in trouble. When she rang him, he immediately responded: "What is going wrong again" – I think he was unconsciously deceiving himself when he had offered to be contacted again. In all likelihood, what we have learned – from clinical work and scientific studies – is that diverse countertransference responses are unavoidingly part and parcel of the work with patients.

**BIBLIOGRAPHY**

1. BECKMANN, D. (1974). *Der Analytiker und sein Patient. Untersuchungen zur Ubertragung und Gegenubertragung*. Huber, Bern Stuttgart Wien.
2. BECKMANN, D. (1988). Aktionsforschungen zur Gegenubertragung. Ruckblick auf ein Forschungsprogramm. In: Kutter P, Beckmann D (Eds) Die psychoanalytische Haltung. *Verlag Internationale Psychoanalyse*, Munchen, pp 231-244.
3. BECKMANN, D, RICHTER, H.E. (1972). *Giesen-Test. Ein Test fur Individualund Gruppendiagnostik.* Huber, Bern.
4. BELLAK, L., SMITH, M.B. (1956). An experimental exploration of the psychoanalytic process. *Psychoanal Quart* 25: 385-414.
5. BETAN, E., HEIM, A.K., CONKLIN, C.Z., WESTEN, D. (2005). Countertransference phenomena and personality pathology in clinical practice: An empirical investigation. *American Journal of Psychiatry* 162:890–898.
6. BETAN, E.J., WESTEN, D. (2009). Countertransference and personality pathology: Development and clinical application of the Countertransference Questionaire. In: *Levy RA, Ablon JS (Eds) Handbook of Evidence-Based Psychodynamic Psychotherapy*. Bridging the Gap Between Science and Practice. Humana Press, New York, pp 179-198.
7. DAHL, H., TELLER, V., MOSS, D., TRUJILLO, M. (1978). Countertransference examples of the syntactic expression of warded-off contents. *Psychoanalytic Quarterly* 47: 339-363.
8. FREUD, S. (1901). Psychopathology of Everyday Life. *Standard Edition 6*
9. FREUD, S. (1910d). The future prospects of psychoanalytic therapy. *Standard Edition* 11:139-151.
10. FREUD, S. (1926e). The question of lay analysis. *Standard Edition* 20:183-250.
11. GRAFF, H., LUBORSKY, L. (1977). Long-term trends in transference and resistance: A quantitative analytic method applied to four psychoanalyses. *Journal of the American Psychoanalyic Association* 25:471-490. Horst Kachele & Ingrid Erhardt 105.

12. GELSO, C.J., LATTS, M, GOMEZ, M., & FASSINGER, R.E. (2002). Countertransference management and therapy outcome. *Journal of Clinical Psychology* 58:861-867.
13. HAYES ,J.A., GELSO, J.C.H., HUMMEL ,A.M. (2011). Managing countertransference. *Psychotherapy* 48 (1):88-97.
14. HAYES, J.A., RIKER, J.B., INGRAM, K.M. (1997). Countertransference behavior and management in brief counseling: A field study. *Psychotherapy Research,* 7:145–154.
15. HEIMANN, P. (1950). On countertransference. *International Journal of Psychoanalysis*, 31:81-84.
16. KACHELE, H. (1983). Verbal activity level of therapists in initial interviews and long-term psychoanalysis. In: Minsel W, Herff W. (Eds) *Methodology in psychotherapy research*. Lang, Frankfurt, pp 125-129.
17. KOHUT, H. (1968). The psychoanalytic treatment of narcissistic personality disorders: Outline of a systematic approach. *Psychoanalytic Study of the Child* 23:86–113.
18. POLANYI, M. (1958). *Personal knowledge. Towards a post-critical philosophy.* Routledge & Kegan Paul, London.
19. SINGER BA & LUBORSKY L (1977). Countertransference: The status of clinical versus quantitative research. In: Gurman AS, Razin AM (Eds) *Effective Psychotherapy*. Pergamon Press, Oxford, pp 433-451.
20. THOMA H & KACHELE H (1987). *Psychoanalytic Practice*. Vol.1 Principles. New York: Springer; 1994 paperback edition Aronson, New York; romanian Tratat de Psihanaliza contemporana. Fundamente. Editura Trei, Bukarest, 1999.
21. VAN WAGENOR, S.L., GELSO, C.J., HAYES, J.A., DIEMER, R (1991). Countertransference and the reputedly excellent psychotherapist. *Psychotherapy*, 28: 411-421.

# Discussions

Discussions

*Commentary on*

# «Countertransference, the analyst's personality and the way in which the analytical relation develops in time»

by Georgiana Dobrescu

*Daniela Irimia*[10]

By means of problematics and clinical illustrations I will try to position this excellent relational paper in the wider context of relational theory, in accordance with Georgiana Dobrescu's request.

The paper is structured around extremely current interrogations on the contemporary dynamics of psychoanalysis. I'm referring to the question to what extent is the analyst's countertransference influenced by the data of his personal psychology, as reflected in the professional training and in the choices of his personal history.

Our whole process of training, personal analysis, supervision, imbibing in clinic various theoretical approaches bears the mark of our unique psychology. Even now I remember that this is how I understood and used the Sponsoring Committee's professional supervisions and evaluations. It is highly important to me that the committee's entire activity should allow us to find and express the personal voice which corresponds to our personal psychology. The essay in which I spoke of personal analysis and the way in which we could use it in our life fits perfectly in the present discussion. It is about the way in which the psychoanalytic relationship and our psychoanalyst's countertransference are used in order to progress and overcome the patterns of our personal pathology.

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What I found to be extremely important in the relational approach which originated from Winnicott's and Ogden's numerous contributions is exactly this new perspective on the way in which change appears in and through the dynamics of the psychoanalytical relationship. It is a perspective which takes into consideration the fact that the patient brings into therapy his relational matrix, in which the therapist inevitably enters, according to his personal history. **It is about an unconscious participation of both sides, the therapist's effort consisting in always being aware and working along with the patient at new patterns of healing interaction.** We relate differently to each of our patients and we know that the second personal therapy with another therapist often changes our old relational matrix according to the new therapist's unique psychology.

In a pertinent analysis, Stephen Mitchel shows that Winnicott, along with Guntrip and Kohut, is the promoter of a way of thinking that anticipated the contemporary relational thinking which includes Th. Ogden. We refer to the developmental-arrest model. This model emphasizes the baby's early relationship with its mother.

Although different in the description of the analytic process, the versions of the three authors have various common points, the use of relational concepts and different techniques in the case of neurotic patients being habitual. Thus, they maintain Freud's classic theory regarding neurosis, considering that the shift from the normal mature development is located in the early mother-baby relationship. The therapeutic action aims to unblock, heal the patient from the pathological interferences of early relationship.

Georgiana presented a subtle and profound analysis of the aperture that Winnicott's writings offer to contemporary analysis and to Ogden's notion. Like Winnicott, Kohut offers a new perspective on the therapeutic process of healing based on a subtle dialectic between gratification and frustration that is tolerable for the patient and which generates, once internalized, a better adaptation of the self to reality, a reconstruction of the forced self, blocked in the traumas of development. Supposedly the pathology generated by the parent's failure, his/her own self experience as being fragile, split, having a major deficit appears from the absence of parental functions as in the case of Winnicott's theory.

Similar to Winnicott, Kohut considers that in analysis, the patient **spontaneously** tends to structure the analytic situation so that it will re-engage in the arrested developmental process. The reactivation of the true self, depends on the therapist's capacity/desire to create an environment fully structured by the patient's subjectivity, in which the analyst, as a good-enough mother, becomes the patient's creation, a subjective object.

Winnicott and Kohut are radical when it comes to a very important point for the classic model: "what matters to the patient is not the accuracy of the interpretation so much as the analyst's willingness to help."

In the classic model, the correct interpretation released the patient from the infantile fixations, for Winnicott and Kohut the correct interpretation, the right attitude is the one which produces a container environment, facilitates regression in those early stages of development and offers a chance of becoming and healing the blocked self.

In this developmental-arrest model what produces change is not the frustration of old desires but the offer of a new environment, the analytic container that although isn't perfect, ideal as it frustrates, it offers a new beginning for the self that stopped developing.

Other relational models that Ogden's concept refers to are those of internal object relations (for instance Fairbairn). In this perspective, the focus lays increasingly on the ability to establish relationships that will facilitate the development of the self, with the exception that the emphasis is no longer placed on early repairing experiences, but on the change of the different sizes of the relational matrix: the organization of the self, the internal relations of the object, transactional patterns.

In a pathological organization of the self, the early object relations are very strong internal occurrences and any new experience is reduced to old traumatic experiences. In this way, the patient is a prisoner of an internal world in which any object is new, the therapist may thus be transformed in a familial (repetition) and familiar presence (which leads to a personal sense of appurtenance and connection).

The therapist inevitably becomes a bad object and the analytic shift is achieved thanks to the interpretation that turns him into a new object. In this way, the patient gives up his compulsive connection with the old

internal relations of the object and can have a different self experience as well as a different experience of his environment. It is often that in therapies during this kind of changes patients do not only modify their image of the self but also their friends, work place, through a strong reconfiguration of their interpersonal world.

In relational thinking, the patient has a paradoxical demand towards the therapist. He wishes him to be, to offer a new experience that goes beyond the matrix and at the same time an old one that is embodied in this relational matrix *"he's inevitably looking for something new in old ways"*.

In Ogden's concepts "the analytic third", "dream thinking" we find a relational analyst who discovers himself as caught in the repetitive structural deadlock of the patient's relational matrix. This struggle for finding another way along with the patient is excellently rendered by Georgiana's clinical examples. The therapeutic third gives notice to this unconscious collaboration between patient and therapist in order to discover new ways to relate so as to overcome the trauma.

The concept of the interactional third underlines the fact that the analyst's experience is necessarily modeled by the patient's relational structures. **He is deeply affected by his patient at the unconscious level or he uses the experience of his own reverie in order to access the unconscious level of the intersubjective experience. It is not a matter of imposing the analyst's subjective experience, but a new creation which occurs as a result of what is said and felt by the two within the relationship.**

Once again, in accordance with the supporters of the relational model, the analyst's unconscious experience is a vehicle for understanding the patient and I would also add an ingredient for therapeutic change.

The way Ogden imagines the analytic situation places him into a participation that is relatively consciously uncontrolled. In his examples we sometimes observe that he either stages the patient's old scenarios or his own old scenarios, according to which each analysand grasps in his unconscious.

Like other relational analysts, he defines the analytical attitude as a permanent effort of reflection and questionnaires of all the data gathered throughout the session. But the unconscious relation to his patient, the

unconscious reverie, often imply moments of feeling guilty, uncomfortable, which are used to understand what goes on within the unconscious of the psychoanalytical relationship. **The analyst's ability to use the reverie for the patient's convenience represents the continuous re-doing of the analytical attitude.**

**The analyst's presence clearly implies two dimensions in the relational perspective – what the therapist tries to do during the session and what he does when trying to be the therapist of a certain patient, i.e. the inevitable unconscious commitment to the patient's relational world.**

**Becoming aware of the unconscious commitment and using its content so that he could find a way, a relational manner, apart from the listening patterns and the patient's experience represent the core of the relational approach. "To say that everything the analysts experiences is countertransference is only to make the self-evident statement that we are each trapped in our own subjectivity. The analyst exists as a separate entity but also as a creation of the analytic intersubjectivity." (Ogden)**

The analyst's effort aims to find a new way of experimenting on himself and on the patient, in which neither of them is only convalescent or detached, victim or abuser, seductive or repellent.

In Ogden's view and in the relational perspective in general, the notion regarding the setting and the way the analytic couple operates during the session supersedes Winnicott's perspective. The analytic change is triggered by this fight between the two participants to jointly overcome, by means of the analytic third if you wish, the old pathological organizations of the patient's world, in which the analyst is now involved and unconscious according to the analytic reverie.

The therapist cannot stay outside the relational matrix; he goes inside of it, feeling its impact according to his own psychology. The therapist's objective is to find a voice and a way to be different from what the relational matrix offers. And it is not about a detached process of understanding, but a permanent inter-subjective collaboration with the patient in order to rewrite old scenarios, transforming the inner characters to an extent that allows new relational positions.

Winnicott's credit remains that of having drawn attention to the fact that in order for the self to occur, at least two people are needed and that

the analytical experience is fundamentally interactive. In the cabinet, in the analytical situation, the patient struggles to have an impact on a certain analyst. The problem is for the analyst to acknowledge and be able to use this impact unconsciously so that the analytical couple changes the old relational model.

## REFERENCES

1. MITCHELL, A.STEPHEN. (1988). *Relational Concepts in Psychoanalysis: An Integration*, Harvard University Press.

# Livre psychanalytique

## Psychoanalysis book

# *L`écorce et le noyau*

## de Nicolas Abraham et Maria Torok

*Gabriel Balaci*[11]

J'ai l'heureuse opportunité de soumettre à votre attention, avec l'intention de provoquer votre curiosité intellectuelle, le livre *L'écorce et le noyau*, étonnant par la richesse des pistes de recherche et de réflexion proposées, et par le regard de ses auteurs sur le psychisme. Les auteurs des articles rassemblés dans ce livre sont Nicolas Abraham et Maria Torok, continuateurs des idées de Ferenczi et de l'école hongroise de psychanalyse. Ces psychanalystes, par leur réflexion et par leur travail clinique ont marqués la pensée analytique
tant au niveau théorique qu'au niveau pratique.

Nicolas Abraham (né en 1919 en Hongrie, mort en 1975 à Paris). A cause de son origine juive il est obligé, à l'arrivée du nazisme dans son pays, de quitter la Hongrie et de s'établir à Paris en 1938. Là, il fait une partie de ses études de philosophie et d'esthétique et puis il continue à Toulouse. Des événements moins heureux, voire traumatiques, qui ont lieu dans sa vie, tels que la folie de sa femme Etla Fryszman et l'extermination d'une grande partie de sa famille par les Nazis ainsi que son besoin d'approfondir sa formation intellectuelle, l'ont poussé à entreprendre une analyse. Il fait sa première analyse avec Bela Grunberg et puis il continue avec Serge Viderman. Il devient psychanalyste, membre de la Société Psychanalytique de Paris en 1959. Depuis 1950 Maria Torok devient sa compagne.

Maria Torok est née en 1925 à Budapest et morte en 1998 à New York. Comme Nicolas Abraham, elle est d'origine juive et issue de la

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bourgeoisie hongroise. Elle passe la période nazie en Hongrie, vivant sous la menace de mort en permanence. Maria Torok quitte son pays et s'installe à Paris en 1947. Au début elle oriente ses études vers les sciences et en 1952 elle se tourne, après l'obtention de sa licence en psychologie à la Sorbonne, vers la psychopédagogie. Elle devient psychanalyste au sein de la Société Psychanalytique de Paris en 1956. Maria Torok a été la première psychothérapeute en France qui a travaillé dans les écoles maternelles dès 1954.

« L'écorce et le noyau » est le livre le plus important de ces auteurs et un des livres fondamentaux de la psychanalyse. Par son complexité il met en difficulté quiconque essaie de le résumer et garantit la perfectibilité de ce travail. Je me suis proposé de présenter ici quelques-unes des idées présentées dans ce recueil de textes magistraux de la psychanalyse, plutôt que de présenter un résumé de l'ensemble de l'ouvrage. Ainsi le plaisir de la découverte des idées et des concepts des auteurs, et de leur vision sur la psychanalyse, restera en grande partie au lecteur.

Cet ouvrage rassemble plusieurs articles écrits ensemble ou séparément et qui reflètent très bien l'orientation des auteurs dans le champ de la psychanalyse. Ces articles se construisent autour de deux concepts essentiels dans la pensée psychanalytique, *l'introjection* comme processus qui permet le développement et le concept du trauma comme blocage de l'introjection. L'objet central de leur pratique clinique, peut-être sous l'influence de leur expérience de vie, est l'âme en souffrance touchée par des blessures profondes, victime de traumatismes, exclusion, violence, haine, persécution. Les articles groupés dans ce livre ont été publiés entre 1959 et 1975 et couvrent des domaines apparemment très disparates : psychanalyse, philosophie, biologie, littérature. Ce livre propose au lecteur diverses pistes de recherche qui lui permettront un enrichissement théorique, mais aussi une possibilité d'auto élaboration.

La pratique clinique de ces psychanalystes met au centre des leur intérêts l'unicité de chacun et l'écoute de cette unicité. Selon Abraham et Torok le but d'une analyse est d'écouter et de permettre aux analysés d'exprimer leur souffrance individuelle qui touche leurs couches les plus profondes.

Sans abandonner les concepts classiques de la psychanalyse tels que Libido, complexe de castration, complexe d'Œdipe, sexualité infantile, N. Abraham et M. Torok apportent un renouvellement important à la théorie psychanalytique. La théorie analytique est considérée par eux, comme étant une théorie de *l'être en tant que symbole*, définition qui pose l'accent sur l'étude du processus de création du sens. Parmi les découverts d'Abraham et Torok, je voudrais mentionner *l'anasémie*, *les secrets de famille* qui sont transmis involontairement d'une génération à l'autre et qui se trouve à la base de la théorie de fantôme, l'enterrement d'un vécu inavouable ou *la crypte*, *le deuil impossible, l'incorporation* qui désigne une identification secrète totale ou partielle. Nous ne pourrions pas ignorer aussi leur vision sur le symbole en tant que « structure de l'univers », qui est abordé dans un double perspectif : phénoménologique et psychanalytique.

Leur passé, trop marqué de soucis, a peut-être un mot à dire sur leur intérêt pour le trauma, autour duquel se tisse leur pratique clinique et l'élaboration des nouveaux concepts théoriques. Sans renoncer à la topique du psychisme proposée par Freud, mais en se basant sur leur pratique clinique, N. Abraham et M. Torok, élaborent leur propre topique. Cette topique est reflétée métaphoriquement dans le titre de cet ouvrage. Dans leur conception, l'être humain se constitue d'une enveloppe, « l'écorce » qui représente le psychisme et « un noyau » qui est le Somatique. Le lien entre les deux niveaux est assuré par les pulsions, les instincts, les fantasmes, les représentations et les affects qui les accompagnent. Les pulsions sont des messagers qui inscrivent les besoins organiques dans le langage de l'inconscient et deviennent conscientes par les fantasmes et par les affects. Les pulsions s'enracinent dans le Sexuel. Selon eux, le Sexuel concerne une partie du Psychique et la totalité du Somatique.

Pour pouvoir expliquer le mécanisme du trauma, les deux auteurs soulignent l'importance de la distinction entre l'introjection et l'incorporation, ainsi que le rôle de la Libido dans la situation de la perte.

Dans l'article *Maladie du deuil et fantasme du cadavre exquis* (1968) [1], M. Torok met au centre du problème du deuil, l'accroissement de la libido du survivant après la perte. Selon Maria Torok, autour de ces sentiments se constitue la maladie du deuil. Cette irruption libidinale qui apparaît soudain, juste avant ou toute de suite après la mort, est honteuse pour

l'endeuillé et peut rendre le deuil impossible. La réaction maniaque qui s'installe après une perte représente une forme pathologique exagérée de cet accroissement libidinal.

Maria Torok souligne l'importance du concept de l'introjection pour la compréhension du problème du deuil. Pour cela, il faut bien différencier le concept de l'introjection du concept de l'incorporation qui est souvent utilisé à la place du premier. Par l'incorporation, l'objet perdu est introduit à l'intérieur du Moi. L'introjection représente notre capacité d'absorption et d'assimilation à travers l'imagination, la création, le travail et le langage. Ce processus évolutif d'auto- élaboration permet l'enrichissement psychique de l'individu. En même temps, l'introjection désigne notre capacité de faire face aux événements traumatiques et aux pertes inattendues.

Maria Torok, reprenant le terme de *l'introjection* de Ferenczi et en lui gardant le sens donné par ce dernier, distingue trois processus inclus dans la notion de l'introjection : « 1. l'extension des intérêts auto-érotiques ; 2. l'élargissement du moi par la levée du refoulement ; 3. l'inclusion de l'objet dans le Moi et, par là, l'objectivisation de l'auto-érotisme primitif. (Abraham, Torok, pp. 236) [1].

L'instinct psychique premier représente dans la conception d'Abraham et Torok, la poussée d'introjection. L'introjection correspond à l'évolution de la vie et de la cure analytique.

A la différence de l'introjection qui n'est pas déterminée effectivement par la perte de l'objet, l'incorporation est déclenchée par cette perte. Pour l'introjection, la perte de l'objet agit comme un interdit et représente un obstacle. L'incorporation de l'objet dans l'intérieur du Moi vise la compensation du plaisir perdu. Le processus de l'incorporation fonctionne selon le principe du plaisir et se réalise par le processus proche de la réalisation hallucinatoire. Ce processus a un caractère instantané et magique qui le différencie de l'introjection qui est un processus progressif. Par l'incorporation le lien imaginal avec l'objet perdu est renforcé, tandis que par l'introjection des pulsions, la dépendance de l'objet est annulée. L'objet incorporé qui remplace l'objet perdu rappelle le désir refoulé. « Monument commémoratif, l'objet incorporé marque le lien, la date, les circonstances où tel désir a été banni de l'introjection : autant de tombeaux dans la vie du Moi (Abraham, Torok, pp. 238).

Le Moi utilise l'ingestion comme expression symbolique de son rapport à la nourriture. Il peut fantasmer de manger ou de refuser la nourriture, en l'absence de l'objet. Dans cette situation on a à faire avec le mécanisme d'incorporation. Ainsi, le fantasme de l'incorporation représente le premier mensonge. La nourriture ne peut pas satisfaire la faim d'introjection, seulement la tromper. Dans la position maniaque, le Moi se leurre par une satisfaction hallucinatoire et illusoire de son désir d'introjection, en remplaçant la satisfaction de ce désir par l'incorporation de la nourriture. Dans la situation où le processus de l'introjection est bloqué, le Moi régresse à ce niveau de réalisation magique du désir de l'introjection.

La reconnaissance de fantasme d'incorporation dans la cure analytique par l'analyste, lui permet d'entendre ce fantasme comme le langage déguisé des désirs (non encore nés comme désir), non encore introjectés et non pas comme une demande à satisfaire. Le rôle de l'analyste dans la cure est de réaliser l'enrichissement du Moi. L'objet est supposé avoir tout ce que le Moi requière pour sa croissance. Dans la situation de perte, la nature du deuil dépend du rôle que joue l'objet pour le Moi à ce moment-là. Si la perte est survenue après l'introjection de désirs concernant l'objet, le deuil n'évoluera pas vers une forme pathologique. Toute l'énergie libidinale dont il a été investi sera retirée dans le Moi et sera disponible pour être investie sur un autre objet nécessaire à l'économie libidinale. Dans la situation où le processus de l'introjection reste inaccompli, le Moi va essayer de maintenir en vie l'objet comme figé dans une Imago. Cette Imago de l'objet s'est constituée comme le dépositaire de l'espoir que ses désirs restés non introjectés se réaliseront un jour. Cet espoir est contradictoire puisqu'il est basé sur l'attente que l'Imago, qui est la gardienne du refoulement, opère la levée de celui-ci.

Concernant la douleur présente dans le travail du deuil, Maria Torok l'explique en partant de la distinction entre l'objet interne décrit par Mélanie Klein, et l'Imago de l'objet. « … le premier étant le pôle fantasmatique du processus d'introjection, l'autre, au contraire, figurant tout ce qui a résisté à l'introjection et dont le Moi s'est approprié par une autre voie, le fantasme d'incorporation. (Abraham, Torok, pp. 246) [1].

D'un point du vue clinique, l'Imago se constitue à la suite d'une satisfaction qui initialement a été acceptée puis retirée et a une fonction interdictrice d'un désir sexuel. Au moment du décès de l'objet, par la régression, la satisfaction hallucinatoire du désir pour l'objet est assouvie un instant. La douleur ressentie par l'endeuillé est liée à ce court moment de satisfaction hallucinatoire dont l'existence est niée par le survivant.

Le désir sexuel pour l'objet reçoit une satisfaction hallucinatoire au moment de la mort de l'objet. Le refoulement supplémentaire qui frappe cette satisfaction magique et détermine l'évolution du patient vers une maladie du deuil longue et même interminable, s'accompagne de forts sentiments de culpabilité. Dans toutes les situations de passage il existe le risque d'apparition d'un conflit entre la nouvelle pulsion et le Moi qui est obligé de se modifier, ainsi que ses relations objectales.

Dans l'article « Deuil ou mélancolie » [2], Nicolas Abraham et Maria Torok, abordent le problème du deuil et ce de la mélancolie dans une perspective métapsychologique.

Le fantasme, qui dans la conception de ces deux auteurs, est de nature narcissique et a une fonction conservatrice, protège une conjoncture intrapsychique qui est visée par un changement imposé par la réalité psychique. Chaque perte impose un remaniement profond que le fantasme d'incorporation prétend réaliser d'une façon magique. Dans la situation de la perte, par le fantasme de l'incorporation, ce n'est pas la perte qui est avalée, mais d'une manière imaginaire, l'objet perdu. Les deux procédés par lesquels opère ce fantasme sont : la dé- métaphorisation et l'objectivation. La dé- métaphorisation consiste à prendre au sens propre ce qui s'entend au figuré. L'objectivation signifie que le sujet n'a pas subi une blessure narcissique par la perte, mais une perte de l'objet.

Par incorporation le sujet absorbe, avale, ce qui lui manque, sous la forme de nourriture imaginaire ou réelle et, au niveau du psychisme, le deuil est refusé. En refusant le deuil, le vrai sens de la perte, le sujet refuse l'introjection.

« Le fantasme d'incorporation trahit une lacune dans le psychisme, un manque à l'endroit précis où une introjection aurait dû avoir lieu. (Abraham, Torok, pp. 261) [2].

Abraham et Torok placent le début de l'introjection tout de suite après la naissance, dans l'expérience du vide de la bouche du nouveau-né doublée de la présence maternelle. Le vide qui s'installe à l'intérieur du sujet après la perte sera rempli par des mots. L'acte de mettre des mots dans le vide créé par la disparition de l'objet, comme dans le vide oral originel, créé par l'absence du sein maternel et qui se trouve à la base de l'apparition du langage, représente l'introjection. Mettre des mots à la place de quelque chose signifie métaphoriser et introjecter. L'introjection, autrement dit, implique la métaphorisation. L'incorporation bloque les mots et tende à remplir le vide par l'absorption d'objet. Ainsi l'incorporation comme fantasme est anti métaphorique.

Pour que la perte engendre une maladie du deuil, l'objet perdu doit être un objet narcissiquement indispensable au moment de la perte. Le désir visé par le refoulement conservateur, opposé au refoulement dynamique, est un désir déjà réalisé et puis enterré. Ce contenu ne peut pas s'exprimer dans des mots. Dans la cure analytique, le mélancolique cherche la reconnaissance de la part de l'analyste de cet amour que lui porte l'objet, le plaisir du sujet de voir l'objet endeuillé pour lui, l'exaltation narcissique du sujet d'avoir reçu l'amour de l'objet.

La fin du deuil suppose la disparition de l'objet pour le sujet. Quand le sujet renonce à sa relation amoureuse avec l'objet, quand il arrive à mettre des mots sur cet amour partagé avec l'objet, mais transformé ultérieurement en secret partagé avec l'objet, le fantôme de l'objet va quitter le sujet, l'objet disparaîtra. La guérison sera complète quand l'objet « aurait accompli le sacrifice suprême. (Abraham, Torok, pp. 275) [2].

Pour Abraham et Torok, la cure analytique a un double but : d'une côté elle doit viser le déclanchement du processus d'auto-élaboration introjective et d'autre côté, dans la situation d'un traumatisme écrasant, elle doit restituer au patient, la possibilité de l'introjection.

Je me résume à la présentation de ces idées en espérant que l'étude de ce livre ne sera pas perçue par les lecteurs comme un « sacrifice suprême » et que son contenu sera facilement introjecté.

**REFERENCES**

1. ABRAHAM, N., TOROK, M. (1968), « Maladie du deuil et fantasme du cadavre exquis » dans *L'écorce et le noyau*, Paris, Édition Flammarion, 2008.
2. ABRAHAM, N., TOROK, M. (1972), « Deuil ou mélancolie », dans *L'écorce et le noyau*, Paris, Édition Flammarion, 2008.

# *Recommendations for authors*

Romanian Journal of Psychoanalysis (R.J.P.) receives original articles for publication (only articles that haven't been previously published in other publications are to be received, in electronic or printed form, in English or French) about any psychoanalytic theme.

The authors are required to follow the following typing rules:

**- The article** is to be written with diacritical marks in French or English, with the abstract and the key-words translated in both languages; the paper will no exceed 20 pages and will be written in Word format, Times New Roman 12 font, Paragraph – Line spacing – double.

It will be sent by e-mail to our editorial office and you will receive confirmation; the page numbering will be: position – bottom of the page, alignment – right.

The article will contain an introduction and, in the end, conclusions and references.

*The first page* will contain: the title of the paper (it should not exceed more than 40 characters), the author's name, his/her affiliation (institution), e-mail address, phone number and postal address for correspondence; a concise abstract (maximum 200 words). The paper is to include an introduction and conclusions and references at the end.

In case the articles are based on *clinical materials*, the author has to confirm that he/she has taken into consideration different methods of protecting patients' confidentiality.

*The footnotes* will be reduced to the minimum and they are not to be used as bibliographical references.

*The quotations* are to be accurately checked, specifying the exact page. Any underlining using italics within a quotation should be indicated as such, mentioning in brackets after the quotation ("my underlining").

*Bibliography*. The references will appear in the text, with the author's name, followed by the publication year and the quotation page, written in brackets as follows: Freud S. (1918, p.87); if there are more than two co-

authors, the text reference will indicate only the first author (Smith et all, 1972); the complete reference of the works quoted will appear in the final bibliographical references.

The authors should limit themselves to the references that are relevant to the article. The authors will be listed alphabetically and their works in the chronological order of publication. If, for the same author, different works published in the same year are quoted, they will be indicated by using the letters a, b etc. When a certain reference does not refer to the original publication, the year of the edition used will be mentioned at the end. In case of translations, the title and the edition of the original source text are to be mentioned in brackets.

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**ex.:** NIETZSCHE, F. (1872). *The birth of tragedy*. Geuss R, Speirs R, editors, Speirs R, trad. Cambridge: Cambridge and New York, 1999.

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La Revue Roumaine de Psychanalyse (R.R.P.) reçoit des articles originaux, (non publiés antérieurement, sur papier ou par voie électronique) en français ou en anglais, couvrant toute question psychanalytique.

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Le manuscrit comprendra une introduction et, à la fin, les conclusions et les références.

*La première page* comprendra: le titre de l'ouvrage qui n'excède plus 40 caractères, le nom de l'auteur, l'établissement d'affiliation, l'adresse courriel, un numéro de téléphone et l'adresse postale de correspondance; un bref résumé (200 mots maximum).

Pour tous les articles soumis impliquant des cas cliniques, leurs auteurs doivent déclarer dans leur lettre d'envoi la méthode qu'ils ont choisie pour protéger la confidentialité des patients.

*Les notes de bas de page* doivent être restreintes au minimum nécessaire et ne pas être utilisées pour donner des références bibliographiques.

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