

CREATIVITY AT RISK IN THE PATIENT/ANALYST DIALOGUE

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PAPER PRESENTED AT LAPSI, LOS ANGELES, IN MAY, 1983

## Creativity at Risk in the Patient/Analyst Dialogue

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As the title of this paper suggests I will be discussing the risks to the creativity of the patient and the analyst in the analytic situation. Because I believe the risks to creativity occur particularly when the analyst is in the grip of countertransference, most of this paper will deal with countertransference phenomena. By way of introduction I will present a view of creativity that has bearing on the analytic situation.

Out of the involvement with the work the artist creates something new and tangible that, at some point, acquires its own life. Even though the analyst is the one who tries to put together something for the patient, the two of them collaborate to create something intangible: a new understanding of an old situation, a new set of feelings, a new integration of experience that has an effect on both of them. When things go well the patient and the analyst have the experience of something developing, acquiring new form, something that, in the sessions themselves, gets progressively richer and more satisfying. If the experience is one of stagnation, of going nowhere, of fruitless repetition, the patient and the analyst face block and impasse. In an earlier paper (1978) I delineated the stages of the creative process that take place in every interaction with the work: perception, elaboration, expression and evaluation. I described the functions of each of these stages to understand the various sources of blocks to creativity. During perception, we take in what is in front of us in the work; This is no simple matter since at times, due to defenses against various anxieties stimulated by what we just did, the taking in doesn't take place. The openness to experience that is a requirement both in art and in psychoanalysis is not a given. The artist, the analyst and the patient may be unable to listen or see the new thing and they rely on the old thing, what they already know, preventing development. In the elaboration phase, what is taken in is brought into contact with other internal experiences where it can interact with them. This new element brought in may stir up contact between one's internal objects which, in turn, may lead to conflict between them and various anxieties. If one defends against such anxieties the new thing

inside remains as a foreign body, encapsulated and prevented from exchanges with the parts of the self that might be reacting to it. If, on the other hand, the new thing we have perceived is allowed to impact us, there might be some internal turmoil, which, if tolerated, can lead to a response, often a surprising one. In the expression phase such response is the next brush stroke, the next sentence, the next interpretation by the analyst or the next association by the patient. The effect of such expression is then assessed in the evaluation phase: how this new addition to the work fits or doesn't, are there corrections to be made, additions, deletions? In the analyst and patient dialogue it means an assessment by both about the truth of the patient's expression, or the correctness of the analyst's interpretation that feels right to both. What is common to these four stages of the creative process is the person's internal freedom to examine and interact with new material and the willingness to experience the anxiety or distress evoked in the process. In addition to talent, the willingness to put oneself under stress seems to be a necessary ingredient in creativity. Not that there is only pain in these stages; as we have all experienced, the rewards for such effort can be immense and is what keeps us all going.

How is what I have said about creative work related to countertransference?

The seminal papers in the 1950's on the meaning and uses of countertransference (Heiman, 1949; Little, 1951; Racker, 1957; Winnicott, 1956) have revolutionized psychoanalysis and have opened the way to examine the patient/analyst relationship. The importance of the analyst's countertransference has since been properly acknowledged but, forty years later, it is still difficult to examine candidly the analyst's reactions to a patient since countertransference is still viewed as a sign of the analyst's neurosis and suggests incompetence. The view of analysis as an enterprise between two people, one of whom has been analyzed, does not imply that the analyst is free from psychopathology (Racker, 1968). The patient's transference is constantly stirring the unresolved issues in the analyst who is as much at risk in the situation as the patient. As Searles (1975) points out, "during moments or even long phases of particularly intense anxiety in his work, the analyst undergoes regression

such that his analytic orientation becomes primitivized (desublimated) to the level of relatively raw aggression and sexual urges (p 123)". Klein and Bion would see this regression as being due to violent projective identification by the patient which stirs up the analyst's own psychotic anxieties and defenses.

What triggers the analyst's countertransference reaction?

Searles has stressed the reality aspect of the patient's transference and candidly admits to the reality of his own psychopathology brought to light by the patient's projections into it. Rather than talking about the difficulties that very disturbed patients create for the analyst Searles illustrates the extent of the analyst's primitive fantasies vis a vis these patients and the analyst's fear of acting out these fantasies. After some years of analytic work with a particularly ungratifying schizophrenic patient he concluded, "I finally realized that it was possible for me to relate to him in some fashion other than the only two potential means heretofore available, those two means being, as I had thought of them, fucking him or killing him. To my enormous relief I realized that I could now be related to him without having either to kill him or fuck him (p123)". In another example, he felt so helpless in his treatment of a paranoid patient that he would succumb to the patient's wish for a magic cure: "...all my conventional armamentarium had failed to help her resolve her psychotic symptoms. Now I would find myself smiling helplessly and pleadingly at the patient, with a feeling of wanting desperately to cure her, somehow, with my love. This, of course, like everything else I had found myself doing did not work, and the intendedly magical love would be replaced by an equally omnipotence-based hatred, such that I would glare at the patient with, for example, a fantasy of burning out the inside of her skull (1975, p.124)". The thwarting of his own therapeutic strivings to cure the patient was leading Searles to psychotic-like omnipotent aggressive fantasies in much the same way as the thwarting of the therapeutic strivings of patients toward their mothers or other family members may have, according to Searles, contributed to the psychosis.

Is the patient the sole member of the dyad who experiences growth? By sorting out his or her countertransference the analyst continues a self

analysis during and after the sessions. Thus, the patient provides the analyst with an opportunity to continue his or her development. In fact, the patient pushes the analyst to develop much in the way the baby pushes the mother to develop, a view held by Erickson (1950) and others. In the analytic situation, the opportunity for development can only be experienced by an analyst who puts him or herself at risk observing and sometimes being at the mercy his or her anxieties. This means that one is willing to work, as Meltzer (1967) puts it, at a maximum level of strain. This is similar to the experience of the artist, stretching and straining his or her capabilities to withstand conflict in the service of the work.

The romantic view of the tortured artist may have helped artists tolerate the various anxieties stirred up during the work. Because anxiety and conflict are considered intrinsic to being an artist, artists are more willing to look into themselves without judging themselves as crazy and if they do so, (seeing themselves as crazy) it does not mean for them incompetence or absence of talent. After all, some of the most famous artists have been confirmed psychotics and, for periods of times, institutionalized. This is not the case with analysts when they have to look into themselves after having acted out in a session. The idea still prevails that if one finds in oneself the raw emotions and impulses Searles talks about one is in desperate need of more analysis. There is a reluctance to seek supervision and help from colleagues for fear of being found out. We don't even want to admit these feelings to ourselves. The literature on countertransference is full of negatively connoted expressions such as "succumb" or "drown" which imply a loss of control. The idea of having succumbed to our countertransference or of having drowned in it is too distasteful to our view of ourselves as both capable of analytic neutrality and of a capacity to maintain the frame. How are these ideas perpetuated?

The examples of countertransference acting out are drawn from supervision sessions where the analyst had succumbed or drowned because of his or her blindness to what the patient was doing; the supervisor is able to point out what was happening then and what the right interpretation would have been. This creates the illusion in the reader that one ought to be able to do as well as the supervisor whose objectivity stems from his or

her distance from the situation. One then expects to be capable of extricating oneself from one's countertransference reactions, of understanding what the patient is doing and of formulating the appropriate interpretation, all on the spot. In the cases where analysts such as Searles, (1975), Rosenfeld (1987) and Kernberg (1976), write about their own countertransference acting out it is clear that the understanding came after the session in question, perhaps only when it was being written up. They have come to accept that while in the grip of counteridentification it is impossible to sort out what belongs to the patient's transference and how it should be understood and interpreted. The fact that the patient has projected an aspect of his or her internal world into a reality in the analyst makes this sorting out a difficult task. With guilt about our own pathology it is hard for us to return to our concern for the patient and to realize that even if he or she has touched similar pathology in ourselves he or she was using us as a target into which to project unwanted aspects of his or her personality. It is useful to remember that... "whatever the analyst experiences emotionally, his reactions always bear some relation to processes in the patient. Even the most neurotic countertransference ideas arise only in response to certain patients and to certain situations of these patients, and they can, in consequence, indicate something about the patients and their situations" (Racker, 1968, p.171).

For a balanced view that considers the unique responses of a patient and what is touching in us we have to tolerate our own pathology, we have to accept that we will always have neurotic and psychotic anxieties and defenses that are likely to be stirred up by our patients. Perhaps we should propose a romantic view of the analyst to be as much a tortured soul as the artist. After all, it is our unfinished business that has made us especially tuned to the needs of our patients. Perhaps, as Searles would say, our therapeutic strivings are our way of curing members of our family via the patient or as Kleinians would say, we are in this business to repair via the patient the unconscious damage we had inflicted on our mothers. Whatever the unconscious reasons for our choice of profession there is something to celebrate about the fact that our analysis and our cure are never completed and that we haven't erected the most adaptive and

perfect defenses. Our countertransference acting out is testimony to our unfinished business but it can be the avenue for growth and development.

How does analytic theory relate to all this? Theories have a paradoxical role in the sorting out of transference and countertransference; they help organize what we observe in a way that makes sense to us and can be communicated to the patient but can be used to contain our anxieties, foreclosing opportunities for further exploration of the patient or of oneself. To work under maximum strain means to challenge one's own theories over and over and to allow oneself misgivings about their capacity to explain fantasies or behavior. It means that for long periods of time we may have to flounder in the unknown and tolerate not knowing such as Bion experienced in trying to analyze psychotic patients. In working, as he prescribed, "without memory or desire" we have less anchors in facts, predictions and knowledge and we open ourselves up for confusion. To work under maximum strain therefore means to accept our neurosis as an assumption, a given, to accept that the greatest gain in our own analysis may simply be a greater capacity to bear conflict and pain, and that this is a great accomplishment. It is this ongoing acceptance and our capacity to withstand pain that will allow us to explore what is neurotic or psychotic in our countertransference and what isn't.

Racker has made a distinction between concordant countertransference and complementary countertransference. In the concordant countertransference each part of the patient's internal world seems to be in alignment with the corresponding part in the analyst's internal world. This resonance with the patient's experience is what we call empathy rather than countertransference and it is therefore desirable. However, concordant identification can become problematic when there is an overidentification with the patient's situation and the analyst loses his or her neutrality and objectivity. By overidentifying with the patient's predominant subjective state the analyst may ignore the split off parts of the patient that need to be integrated. In the complementary countertransference the analyst identifies with one of the patient's internal objects that he or she has projected into the analyst. The most common example of this is for the analyst to identify with the patient's superego

and find him or herself critical of the patient. The analyst's response is a reaction to the patient's tendency to project his or her super-ego into the analyst which leads to a paranoid transference. If the analyst acts out his or her countertransference feelings and is in any way critical of the patient he or she is perpetuating a vicious circle for the patient by entering into the patient's internal drama. This produces repetition and stagnation, the opposite of a creative new solution to the dilemma. If the analyst uses his reactions to understand that a part of the patient must be feeling criticized by the patient's superego, the analyst can convey this understanding in an interpretation that will make a breach in the vicious circle of the patient's dilemma, namely, being paranoid toward authority figures and unable to discern whether they are in fact critical of him or her.

How is the analyst response to countertransference related to creativity? We seem to fluctuate between concordant and complementary countertransference, from resonating with the patient, to being troubled by him or her. In fact, we may be unable to stay in a concordant identification with the patient because resonating with the patient's experience is threatening to us. This leads us to a complementary identification in which we are compelled to become one of the patient's objects. It is the troubled feelings, the turbulence we experience vis a vis the patient that offers us an opportunity for creative work. It forces us to shift gears in order to go back to a concordant identification. An interpretation that does not take into account our countertransference feelings when they do exist tends to either be superficial because the facts pointed out are too near consciousness or an application of theory that is experienced as too abstract by the patient and does not convince us either. The compulsive nature of such an interpretation suggests that it is protecting us from anxiety and that unconscious countertransference is at work. On the other hand, an interpretation that engages our countertransference, even if incomplete, is more alive and opens up to new feelings and experiences in the patient. Grinberg (1962) offers an example in which his interpretation denied countertransference by implying the usual "it is not me, it is you" response to the patient. His own feelings of dissatisfaction with the interpretation led him to look into his

countertransference and to a more satisfying response for both him and the patient.

How does the analyst extricate him or herself from the patient's projections? The literature on countertransference is replete with examples of interpretations that didn't take account of the countertransference, leading nowhere, and those that did, that opened things up. As Racker pointed out in 1951, in the unconscious of the analyst countertransference feelings seem to respond to the law of talion. At an unconscious level of mind aggression is responded to with aggression: If the patient is scornful of the analyst, the analyst will find himself or herself wanting to retaliate with a similar attitude; if the patient is silent and withdraws from the analyst, the analyst will find him or herself wanting to punish the patient with silence and, if the analyst retaliates in this way, a battle of wills may ensue as to who will breach the silence first. These reactions are considered anathema to what a good analyst should feel and do and we go through great pains to avoid them. In these cases it is easy to resort to theory to understand what is going on in the patient - we are no longer interested in finding out what our response is but in applying what we already know, foreclosing an opportunity to discover something new.

Borderline, narcissistic and psychotic patients induce powerful countertransference feelings in us that can be hard to admit to, lest we acknowledge being as disturbed as the patient. Being aware of our feelings puts us in touch first of all with our retaliatory response that tends to be blocked. The productive use of countertransference is then lost and analysis becomes, once again, the work of one person trying to understand another, not the risky and creative endeavor that analysis can be where there is potential growth for both analyst and patient. This unwillingness to listen to one's countertransference has a constricting effect on the patient as well who remains locked in the vicious circle that brought him or her to analysis. The patient battles unsuccessfully to be understood within the parameters of the analyst's interpretation, or battles to break through the constraints of the analyst interpretation. One solution to the patient's dilemma is to submit to the analyst view by identification with him or her in order to maintain the so needed connection with the analyst. This is the

tragic case where analysis becomes indoctrination and where the creativity inherent in the analytic situation is lost. It is also important to keep in mind that, as Racker pointed out, "the patient is the chief object of direct desires in the analyst, who wishes to be accepted and loved by him (or her)" (1968, p.165). If we thus have an unconscious transference aim of making the patient dependent on us we will respond with countertransference aggression when the patient does not depend on us. This creates a dilemma when we attempt to interpret the patient's resistance to dependence on us. We need to ask ourselves, is this interpretation for the patient's benefit or ours?

Searles has given some poignant examples of his early inability to appreciate what his schizophrenic patients were doing for him. He has shown how, out of ignoring his countertransference, he missed many opportunities to acknowledge the patient's attempt to cure him in the mother transference. His feeling too elated and self-satisfied after a session, for example, a sign of countertransference, had been blocked; analysts are not supposed to feel good at the expense of the patient. Once he overcame such judgement and admitted these feelings to himself he not only was able to understand the patient better but was able to see how important the striving to help the mother in the analyst may be for the child part of the patient. Many analysts are locked in the view that schizophrenic patients dread dependency. They and can only see in their patients an attempt to turn the tables on them by having the analyst need them. As a result of his admitting his countertransference feelings and then deducing the nature of the patient's projection that had instigated those feelings, Searles was able to see psychosis as stemming from the parent's inability to acknowledge such attempts by the child and of the analyst perpetuating this failure for the patient.

Searles' creative leap was to see the analytic situation in a way that was the opposite of the one traditionally held. This resorting to the opposite as a solution to a block to creativity is well known among artists. In a lecture on his own creativity composer Pierre Boulez contended that he seldom follows his intuition. He has come to mistrust it because it usually leads him to repeat what he already has done before. Therefore, faced with an

impulse to do something in a particular way he will choose to do the opposite in order to open for himself new ways of doing things. Artists do the same by capitalizing on accidents in the work. If need be, an act of ruthless destruction of an aspect of the work will have the effect of opening up new possibilities. Boulez's solution may help us shed some light on the countertransference dilemma. Countertransference acting out may be detected when the analyst finds himself or herself saying or doing something atypical. The urge to make an interpretation may be an impulse to enact the patient's projection. We may be able to extricate ourselves from this urge by imagining taking the opposite course of action. Kernberg and his collaborators (1989) go beyond that suggesting trial identifications with the entire cast of characters in the patient's internal world.

It is important to have clear cut notions of what is or is not part of the contract with the patient. Deviations from the frame revealed by the analyst's atypical response can signal to him or her that unconscious countertransference is at work. Kernberg (1989) contends that any therapist treating borderline patients must accept the fact that some acting out of the countertransference will take place and suggest that... "When this happens the therapist should acknowledge to the patient the innappropriateness of his or her behavior as a first step in restoring technical neutrality" ( p.85). The controversy about admitting our mistakes to our patients may reflect our relative reluctance to truly examine our countertransference. In addition, admitting a mistake to a patient may threaten the patient's dependence on us and his or her idealized transference toward us. We may also fear the patient's anger at our mistake, which puts us in danger of projecting our super-ego into the patient and of having to, in our own eyes, come down from our lofty position as the analyst who knows better. The argument in favor of not disclosing one's mistakes to patients considers that such admission becomes a burden for the patient. One would have to ask again whose burden are we concerned about. Admitting a mistake certainly opens up the analytic situation in unknown ways that will disrupt the status quo of the situation and may induce strain for the analyst.

The capacity to observe our countertransference entails withholding judgment toward our own reactions. Some years ago Tim Galway gave a demonstration of tennis on TV where he had beginners serve the ball and then describe the outcome of the serving, where the ball landed, how many bounces it made and in which corner of the court it ended up. After several trials where no judgment by the student or the teacher was being made and where the attention was focused on observing the whereabouts of the ball, these beginners were consistently hitting the ball correctly. These players' super-egos were no longer attacking them after a poor serve and interfering with the attention necessary for the next one. By observing the ball without judgment the body had been released to follow its wisdom. It is tempting to apply Galway's demonstration to the analytic situation and imagine that one could be freed from such nagging demands to have nothing interfere with the perfect, complete interpretation, to feel nothing that disrupts our peace of mind and that challenges our position as a competent analyst. Our turbulent states would then become a source of curiosity and challenge: What am I feeling? Can I withstand this feeling? If I had it my way, what would I want to say or do to the patient? The application of theory to understand what is happening would only come in after this observation and would be enriched by what we discovered. As pointed out earlier, we might have to wait and get the understanding after the session, making use of that understanding in ensuing sessions when the turbulent feelings surface again, not in the present one. We can begin to accept that this present session where we are disrupted is for the experience, for the learning and that there will be a lag before this learning can be applied to helping the patient understand his or her transference. In creative work we don't expect that our response to something we have done will require an immediate decision as to what to do next. We take our time to absorb the disrupting effect of what we just did. It has to be digested by having it interact in our unconscious with many aspects of ourselves. Why should it be any different with an analyst at work that has even less control of "the other" than the artist with the work in progress?

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