Analyst Resistance - Problem or Opportunity?

The conception of what occurs in the analytic setting, and more importantly, what should occur, has evolved greatly since Freud's pioneering work. This evolution is perhaps most clearly seen in ideas about the appropriate relationship between analyst and patient, especially in the attitude to countertransference. I plan to sketch some of the development regarding these issues as far as they clarify the classical Freudian view. I will suggest that the patient's resistance echoes the resistance of the analyst. In this sense all resistance in the analytic setting originates fundamentally with the analyst. And the resolution of the analyst's resistance is the necessary condition for continued progress in psychoanalytic treatment.

In classical Freudian psychoanalysis the analyst is supposed to achieve a neutral perspective and to master his own subjective process. Ideally he is the instrument of knowledge which reflects, without distorting, the patient's unconscious. This desire for objectivity in the analyst is a trait of empirical science. More contemporary theories stress the value of the analyst entering the interaction by acknowledging and using his subjectivity; both patient and analyst engaged as participants. It is interesting to note that this development in theory approximates the more general shift in cultural and social sciences from the positivistic/empirical model to a more hermeneutic understanding. In *Knowledge and Human Interests*, Habermas examines this development in science, with special regard to psychoanalysis (1972,pp.161-288).

In order to examine the question of analyst resistance, the discussion with introduce the concepts of resistance, transference, the training analysis, and countertransference. This will be followed by a discussion of analyst resistance and whether it makes sense to view all resistance in analysis as fundamentally the analyst's. I will concentrate on Freudian theory but will mark where the hermeneutic perspective appears, and what significance this may have to this discussion.

Resistance

In *The Language of Psychoanalysis* (Laplanche and Pontalis,1983,p.394), resistance is defined as '...everything in the words and actions of the analysand that obstructs his gaining access to his unconscious.' Greenson, in *The Technique and Practice of Psychoanalysis* (1967, c.f. Malin, 1993,p.505), defines resistance as referring to '... all the defensive operations of the mental apparatus as they are evoked in the analytic situation ... In the psychoanalytic situation the defences manifest themselves as resistances'. Resistance is a feature of the analytic situation. It seeks to halt the analysis due to the danger of anxiety and pain. Analysis, using interpretation, attempts to bring into consciousness what is unconscious. This process can produce insights which upset the individual's intrapsychic balance.

Resistance and repression originate from the same force which works against making unpleasurable ideas conscious. Resistance can be either conscious (for example, repression and transference), or unconscious (from the id, unconscious ego, and superego) and is triggered by an interpretation which elicits pressure to de-repress, or recollect. It is a definite "No" to this interpretation, to the analysis, and the analyst. The degree of resistance increases according to how close the repressed content is to the pathogenic core (Lacan, 1954,p.36).

Freud's initial reaction to resistance was to persuade the patient, cajole him into overcoming it, until he realised that the patient's resistance could indicate what it resisted - it was a clue to the repressed. It had to "know" what it was keeping unconscious in order to effectively do so. Therefore interpretation of the manifest resistance is the available means into the latent content. Freud's medical background is evident in his view of resistance as a symptom, and a cunning and devious one. This contrasts to some contemporary views which stress the positive aspect of the resistances, that they serve a protective function and should be respected; '... they constitute valuable moves to safeguard the self, however weak and

defensive it may be, against destruction and invasion ...' (Kohut,1984,p.41).

Freud eventually saw the whole work of analysis as the overcoming of resistances (Bettleheim,1982,p.86). The manner of gaining insight became more significant than the actual piece of knowledge. Freud described the process as the imparting of a conscious interpretation which, if close enough to an unconscious idea in the patient, will overcome the resistance between conscious and unconscious and the patient will find the piece of self-knowledge himself (Wolstein, 1988,p.17). What has been termed 'subjective knowledge' (Bettleheim,1982,p.87) or 'evocative knowledge' (Young,1994,p.53), has, in its overcoming of resistance, the power of deep personal transformation.

It is no accident that Freud does not pay equal attention to resistance in the analyst. Freud expected the analyst to act as a "mirror". To be "cleansed" by his own training analysis. Therefore resistance in the analyst is an indication that his training analysis was incomplete. It is a fault in the (objective) instrument of analytic knowledge. Freud acknowledged that an analyst can only formulate ideas and interpretations as far as his own analysis has taken him, in effect his own resistance to certain material setting the limit to its recognition in a patient. Again, Freud's response is to stress the

[illegible]tion. The analyst has entered the analytic frame as an historical person whose conscious and unconscious resistances cannot just be somehow bracketed. As we shall see, the countertransference could be thought of as a manifestation of analyst resistance. The focus on the analyst also is a feature of a more hermeneutic perspective. A short discussion of the training analysis is appropriate since Freud saw this as the remedy for resistance in the analyst.

The Training Analysis

The goal of training analysis is not to become fully analysed or perfect, but to achieve an appreciable degree of personal 'self-mastery' as Freud often put it, or in less controlling language, to develop an inner relationship which will allow self-awareness rather than acting out when listening to the unconscious of the patient. This requires a lowering of personal resistances and an openness to continuing self-inquiry. In 'Analysis Terminable and Interminable', Freud says

> We hope and believe that the stimulus received in the learner's own analysis will not cease to act upon him when that analysis ends, that the process of ego transformation will go on of their own accord and that all further experiences will be made use of in a newly acquired way. This does indeed happen and, in so far as it happens, it qualifies the learner who has been analysed to become an analyst (1937,p.352).

It is a strong claim that continuing self-analysis is the norm and is effective. It is not apparent that one individual can always, while under the influence of an unconscious resistance, analyse that resistance. For this reason Freud came to recommend that each analyst return to analysis every five years. This is recognised by Maria Kramer (1959,p.17) when she says that the self-interpretation of transference is limited by so-called 'blind spots'. She says these

can sometimes be removed through free-association but that often the resistance's are too strong. (Kramer describes what she calls an auto-analytic function, which must be developed as a natural and spontaneous ego function during the training analysis otherwise the analyst will need to return to analysis to develop it).

The actual situation of the training analysis must also be acknowledged. That is, a practising analyst is training another to be an analyst, a rival, and may have interests in not allowing him to achieve equality. The training analyst's resistance will affect his student analyst, whose corresponding complexes will remain unanalysed. This in turn sets the limits of treatment for the new analyst's patients. The student's desire for an idealised parent and the training analyst's need for an idealised child can hold back the candidates progress and lead to interminable analysis (see Limentam,1974, p.75). Arnold Z. Pfeffer (1974,p.80) has highlighted another aspect of the training analysis; the role of the analyst as evaluator of the student. He questions the value of an analysis which is not confidential and which can impact negatively on the student's professional future.

The training analysis is crucial to the competence of the resulting analyst. Not only is it the opportunity to work-through his resistances, it also teaches him how to self-analyse, (or it develops the auto-analytic ego function). From a Freudian perspective this is the necessary state referred to as self-mastery. It is meant as the safe-guard against an analyst's resistance influencing the analysis; either by affecting the patient's unconscious process, by self-disclosing countertransference feelings, or by acting out in some other way. Freud stressed the training analysis is essential to 'purify' the analyst's complexes and internal resistances (Laplanche and Pontalis,1983,p.92; Freud,1912,p.116), so that they will not limit the progress of the treatment. The biases in the analytic training situation would not appear to facilitate the goal of self-mastery. The resulting analysts cannot be assumed to have achieved Freud's ideal.

Transference

In *The Language of Psychoanalysis* transference is defined as usually being a development of the analytic treatment. It is the actualisation of the patient's unconscious wishes in the specific analyst/patient relationship. 'In the transference, infantile prototypes re-emerge and are experienced with a strong sensation of immediacy' (Laplanche and Pontalis,1983,p.455). The analytic cure can be defined as the resolution of the transference, which embodies all the basic issues presented by the patient.

There are controversies regarding the use of the term transference (Laplanche and Pontalis,1983,p.456). Also a question as to whether it is a consequence of the analytic situation or if it occurs outside analysis, in other relationships. Here we will take transference to mean the projection of unconscious ideas and affects from the patient onto/into the analyst. In other words, the analyst takes the place of some significant earlier person (usually a parent) from the patient's history. The transference can be either positive or negative, and as it replaces the ordinary neurosis, becomes a transference neurosis.

According to Freud, transference appears in every 'serious analysis' right at the moment when crucial repressed contents could become conscious. In this respect transference is an attempt at resistance, but like other resistance, it actually brings to the surface the unconscious conflict which it is protecting: '... [it is the transference which does us] the inestimable service of making the patient's hidden and forgotten erotic impulses immediate and manifest' (Freud,1912,p.108). Freud recognises the powerful effect of interpreting the transference, and comes to see it, rather than recollection, as the ideal of treatment. (Later theorists will claim the transference as the most important development of the analysis, a chance to experience infantile affects and to resolve problematic patterns of relationship).

According to Freud, a transient transference usually occurs at the beginning of

analysis and this develops into a transference neurosis if the analyst times his interpretations correctly and maintains a trusting working alliance which neither contaminates nor inhibits the evolving transference (Greenson, 1974,p.43). The response of the analyst, the timing and wording of his interpretations, is crucial to the developing process. The analyst's feelings, conscious and unconscious, determined by his resistances, will influence his ability to shadow the free-associations of his patient, affecting the efficacy of his input. The analyst's containment of the transference, his countertransference, thus affects the success of the whole therapeutic process.

Countertransference

Only late in his writing did Freud acknowledge the patient's influence on the analyst's unconscious. Countertransference has been described as 'The whole of the analyst's unconscious reactions to the individual analysand - especially to the analysand's own transference' (Laplanche and Pontalis,1983,p.92). Countertransference can refer to everything in the analyst's unconscious which surfaces as resistance during the treatment. Or it can have the more restricted definition of the analyst's unconscious response to the patient's transference. However, it is not clear how the analyst can determine whether the feelings evoked in him during the analysis are the consequence of the patient's transference or the result of unanalysed resistances originating in the analyst. Since the resistance appears during the session, it is assumed that it has been triggered somehow by that situation with that specific patient. But what is being "triggered"? It could be a countertransference to the patient's transference, or it could, for example, be a memory of the analyst's relationship with his own father. The fact that it has been triggered then probably gives some information about that analytic moment, about the patient's process, but it is also clearly about the analyst's life. If the memory provokes strong anxiety, and thus resistance in the analyst, then the patient will be prevented from pursuing their material. The patient will have lost his "companion unconscious", evidenced by the analyst's inability to offer useful interpretations on a topic which is too close for him, and which may cause him visible distress.

For Freud, this is the negative type of countertransference, a "fault" in the analyst which requires further analysis

Freud remarked that 'everyone possesses in his own unconscious an [illegible]the psychoanalytic relationship. Since Freud, the countertransference has received increasing attention as psychoanalytic study develops hermeneutically.

Discussion

The countertransference and the transference begin to develop before the analyst and patient even meet. The patient has expectations, past experiences, hopes and fears, providing a kind of psychic set for the initial interactions with the analyst. The analyst has expectations of his patient, how the analysis should go, and a human reaction to the appearance of the patient. The analyst also has his or her own interests; the reasons for becoming an analyst, professional interests of prestige, making a living etc.

It is worthy to note that the sessions do not occur on neutral territory, it is the analyst's home ground, and although there is a indictment against having many personal items on display, it may be safe to assume that some of who the analyst is will come across in

the details of the room as well as in the manner of his/her dress and appearance. It could be argued that the consulting room is furnished by the analyst's own 'narcissistic countertransference' (Ferenczi and Rank, c.f. Wolstein, 1988,p.33), as much as by a couch, chair, and pictures.

From the outset then, the patient is faced with the world of the analyst - visually, consciously, and unconsciously. The analyst is faced with the world of the patient as it is carried in his/her personal appearance, consciously and unconsciously. It is the analyst's countertransference (and counterresistance) which sets the limit of the analysis because of the role the analyst is in. The analyst is in the role of healer, the position of being-for the patient. The analysis is facilitated to the extent that the analyst can fulfil this role. The analyst's resistance obstructs this task in the following ways:

1. In *Mental Space*, Robert Young writes of countertransference as a form of 'projective identification' in which '... the patient puts something into the therapist which the therapist experiences as his or her own' (1994,p.56). Young points out that the projected feeling needs to be in the repetoire of the therapist to some degree to be exaggerated by the patient's transference. Since the projection has a basis in reality, the therapist must be able to stand the anxiety it may provoke in order to investigate his countertransference as a clue to what the patient is "disowning". Roger Money-Kyrle says, '... [the analyst's] understanding fails whenever the patient corresponds too closely with some aspect of himself which he has not yet learnt to understand' (1956,p.361). This is the case of resistance affecting the analyst's understanding.

2. The analyst's relationship with his resistances must be such that he can contain the transference without retaliating. 'Projective identification makes it possible for [the patient] to investigate his own feelings in a personality powerful enough to contain them' (Bion,1959,p.314). Eventually these split-off parts of the patient are re-introjected, marking a vital point in the treatment. If the analyst cannot respond in the appropriate manner (usually

abstinance, in Freud's view), the patient will construct a resistance as a consequence. The patient's resistance says it is not safe to experience this material here, with this analyst (or it produces a guilt response in the patient, for example). Unless the analyst can recover, this impasse could produce an interminable analysis. In this situation the analyst's resistance causes a resistance in the patient.

3. The analyst is not a neutral 'emotionally cold' instrument, as Freud imagined. He is a whole human being, as unable as anyone else to bracket his own 'lifeworld'. Becoming an analyst teaches skills and theory, but does not dissolve a person's unique biography, sensitivities, values and prejudices. The emotional involvement of the analyst can be equal to that of the patient. Accepting this reduces the pressure to remain unaffected by the other's difficulties, and the resulting claim by analysts that their own deficiencies are caused by their patient's material (this concern is attributed to Klein,c.f. Young,1994,p.69). This resistance can result in the analyst blaming the patient for the analyst's own unresolved complexes. Again, acknowledging the analyst's affects is a move away from the empirical desire for objectivity, toward the hermeneutic participant-observation model.

4. The analyst can be blocked in his own self-analytic attempts during a session. Due to his resistance he cannot offer a (complete or valid) interpretation. In fact the patient may be able to follow his own thought further than his analyst can. The analyst '... might then defensively confront the patient with a feeling that only he, the analyst, can produce a valid insight' (Kramer,1959,pp.22-25). In this case the analyst's resistance may not block the patient initially, but the analyst's reaction to his resistance may prohibit the spontaneously emerging insight in the patient. This resistance can stop the 'auto-analytic' ego function from developing (Kramer,1959,pp.17-25) and may also produce a misinterpretation, or a poorly timed one. The patient's trust and developing analytic skill will be damaged.

5. Resolution of the transference and the countertransference go hand in hand. Harold Searles stresses the point that '... before an analysis can properly terminate, the

analyst must have experienced a resolution of his countertransference to the patient...' (1959,p.181). Searles recounts, with remarkable candor, a case in which his own anxiety caused him to flee from further analysis with a specific patient (p.185). He ascribes his experience to an aspect of his unresolved oedipus conflict. Further self-analysis enabled him to contain these feelings in the next patient who evoked them. In the first instance, the analyst's resistance inhibited resolution of his countertransference, and thus successful termination of the treatment.

6. Being able to follow a patient's descent into the unconscious requires a corresponding regression in the analyst. Stephen Sonnenberg believes that when analysts regress,

> ... inevitable errors will occur and blind spots will affect their work. That is because when we analysts work in that way we often rely heavily on our own experiences to understand those of our patients, and it is then inevitable that our own conflicts about our experiences will stand in the way of our understanding what we are trying to tell ourselves about ourselves and our patients (1995,p.341).

Sonnenberg is writing about a measure of resistance that is unavoidable in the analyst. The analyst's experiences are the guide and potential source of distortion. He recounts a case in which his recollection of longing for his father provided a clue to what his patient was feeling but was also very painful to consider. He says that his own self-analysis made that consideration possible. Otherwise the anxiety of recollection would have resulted in resistance and the analyst would not have recognised the repressed content in the patient. It is important to note that some resistances are inevitable, and both a hindrance and tool simultaneously.

7. Benjamin Wolstein writes of the patient evoking self-knowledge in the analyst. This suggets that in some form there are two analyses occuring.

> When patients observed some unconscious or dissociated aspect of their psychoanalyst's psychology not yet fully interpersonal, psychoanalysts were not as readily able to fall back on the adaptive or consensual understanding of how their patients were perceiving them. This countertransference was as yet unavailable to their conscious reach, they therefore tended to

> *counterresist.* Because they could not as quickly bring it to conscious awareness, they usually remained silent and/or claimed it for further personal analysis, effectively removing it from that phase of the clinical psychoanalytic inquiry. (1988,p.10).

From my own clinical experience I have found that clients resist feelings which I resist in myself. As I give myself permission to cry, for example, my clients were released to find their own tears. It seems there is a deep communication between two unconsciouses. It may be that the analyst's resistance is evident in his non-verbal behaviour. 'The slightest gestures of the analyst, whether he speaks or keeps silent, smiles, smokes, or remains still: all these aspects are interpreted with respect to the patient's wishes' (Berry-Bertrand,1974,p.471). The patient is interpreting the analyst according to his own fantasies, while the analyst is doing the same. The hermeneutic aspect of this relationship does not lessen the fact that the participants remain in different roles. The analyst's openness to learning from the patient instills confidence in the psychic strength of the analyst, and facilitates the comparison of the patient's fantasy relationship with reality.

8. Angel Garma (1974,pp.371-376) says that as analysis nears its end, the analysand can react phobically to the possibility of further improvement and the analyst, representing the analyst's superego, is the transference cause of this phobic reaction. Freud witnessed this phenomenon,

> It is not important in what form resistance appears, whether as a transference or not. The decisive thing remains that the resistance prevents any change from taking place - that everything stays as it was. We often have the impression that ... we have penetrated through all the psychological strata and have reached bedrock, and that thus our activities are at an end (Freud, 1937, c.f. Garma, 1974, p.371).

But whose resistance is it? The analysand fears being too perfect, and experiences the analyst as maintaining him at an inferior level. How did the analyst come to embody such a threat to the analysand? It could be due to analyst resistance, an acting out by the analyst, or a projection by the patient, but the transference could not occur unless the analyst had some possibility of receiving it. The role of the analyst does approximate the father; powerful, knowledgable. So this phobic reaction could be a possible artifact of the analyst's way of

working (especially in classical Freudian analysis). The patient's resolution of the transference will depend on the analyst's ability to interpret his countertransference.

9. Adhering strictly to theory can be a mode of analyst resistance, evoking resistance in the patient. Arthur Malin (1993) recounts a case where the analyst's view of resistance had to change in order to continue with the analysis. The analyst moved from a classical Freudian view of dismantling and interpreting the resistance to a position of respecting it. She recognised that she had been contributing to the patient's resistance until she acknowledged the legitimacy of his point of view (he had asked her to keep completely silent), '... to reframe what had previously been viewed as analysis-impeding resistance as a strategy of self protection positioning the patient for resumed growth - seemed crucial to the eventual therapeutic result' (Malin, 1993,p.517).

Summary

I have presented nine possible ways that analyst resistance can be seen to be the fundamental source of all resistance in psychoanalytic treatment. Some of them overlap, and it could be as simple to list nine sources and consequences of patient resistance. However, the role of the analyst, especially in Freudian theory, is to guide, interpret, and contain the patient's experience. When the analyst cannot fulfil his role, the therapy reaches its limit. The patient's resistance can be seen as a result of this. The analyst's countertransference can be the result of his attunement or his resistance to the patient and the patient's material. In the first case Freud saw the analyst as functioning as the clear instrument of analytic knowledge. In the second case Freud recommended that the analyst seek further analysis.

The shift from an empirical to a hermeneutic perspective means that the analyst's position as a human being is recognised. It is not possible, nor necessarily desirable that the analyst attain objectivity. Both subjectivities are sources of knowledge, inter-psychic and intra-psychic. The subject - object polarization is replaced. The subject of study becomes

the relationship. Objectivity evolves into a '... form of internal division that enables the analyst to make himself (his own countertransference and subjectivity) the object of his continuous observation and analysis' (Racker,c.f. Wolstein,1988,p.162). The distance between the analyst and patient decreases. And the analyst's resistance is accepted - it is no longer a shameful secret (potentially lessening 'indirect counterresistance', like the fear of loss of peer respect, see Casement,1985,p.127). This freeing up of the analyst (to admit his own experience) may facilitate an attitude of empathy.

George Pigman has offered an interesting account of Freud's use of the term empathy (1995,pp.238 -252). He says that 'Einfuhlung' has been mistranslated from the German and should be translated into English as 'Empathy'. It '... describes for Freud the process of putting oneself into another's position either consciously or unconsciously, and he will continue to use the word in this way for the rest of his life' (p.246). Pigman continues by saying,

> ... if the analyst cannot adapt an empathic stance, the positive transference necessary to allow the patient to benefit from interpretations of his symptoms will not develop. An empathic stance is thus a prerequisite for the curative agent of analysis, interpretation. Further, this stance requires the analyst to put himself into the patient's position, to understand the patient's experience from the patient's and not anyone else's point of view. (p.246)

Resistance in the analyst could impair this ability to fully empathise with the analysand, to interpret sensitively, and to develop a positive transference. If empathy is present, a transference/countertransference relationship develops which facilitates the treatment. In the words of Glen Gabbard, 'The patient and analyst enter into a relationship in which they are simultaneously separate but also "at one" with each other. A unique subjectivity is created through the dialectic of interpretation of subjectivities' (1995, p.477).

To experience this genuine empathy, the analyst must be open to his own suffering. To openly receive the patient's experience he must have the ability and permission to relate to it. This enables the patient to share, in the transference, content which will select and exaggerate a piece of the analyst. This is a reference to Jung's concept of the 'wounded

healer' (see Hillman,1979;Jaspers,1964;Neuman,1959). Empathy operates in both directions. In *The Analyst's Act of Freedom As Agent of Therapeutic Change* , Neville Symington writes that after three years of analysis he realised that a patient of his was saying '... she could only move when an inner act of freedom had occurred within me. I had not realised at this stage that she was able to "know" when these occurred' (c.f. Kohon, 1986,p.264). As the relationship is acknowledged to be two-way, there is a recognition of the need for a suitable character match between the analyst and patient to avoid the situation where they may collude to maintain a shared resistance.

Throughout this paper I have woven recent developments in psychoanalytic theory with the classical Freudian view. Freud's view of the analyst's role, his resistance and countertransference, has been challenged by the evolution of a hermeneutic participant-observation perspective. According to classical theory resistance in the analytic setting is fundamentally the analyst's. The patient manifests resistance but this can be seen as always a response to the analyst. It is negative when the source of resistance is an unanalysed part of the analyst. It is valuable when the resistance is manifested as transference (and its corresponding countertransference). The working-through of this is the task of analysis.

On the other hand, the hermeneutic view stresses the relationship of analyst and patient. Having low resistance in order to make brilliant and well-timed interpretations is not the point. Rather, there is a deep interplay of conscious and unconscious resistances, creating a therapeutic space which is the object of study, and perhaps play. Each person has the opportunity to try on the other's role, or projected parts, and to investigate their own split-off aspects. The analyst still has a special responsibility which his training analysis, knowledge, and experience prepares him for. But he is present as a whole person, not an analytic instrument. I believe that this development in theory affects the manifestation of analyst resistance. It removes the stigma, permits the analyst to entertain his resistances, and opens up the discussion. Resistance is seen to be natural and unavoidable. The analyst's resistance can be a source of reality for the patient and a source of self-knowledge for the

analyst.

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