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This article presents an integration of psychoanalytic and creative art therapy concepts in an attempt to expand the parameters of what psychoanalysts call “totalistic” countertransference. The totalistic view of countertransference, regression and empathy, and projective identification are described and discussed, followed by a brief section on visual reception in which the author supports the belief of the necessity for making creative art materials available to both the patient and the analyst during the session. When art materials are used, identification and understanding the significance of images can take place. A clinical example (Miss A.) is presented; the patient is a 33 year old artist who began psychoanalytic psychotherapy two years previously, and currently is better able to understand some of the aspects of attachments to a boyfriend and to a clinging mother. Intellectual, disconnected experiences were evident from the patient’s past experiences, and the author points out the need—and some procedures—for resolving this disconnectedness. A brief discussion of the case is presented, followed by a summary statement regarding a technique, with appropriate cautions given.

Introduction

A focus of this article is on an integration of psychoanalytic and creative art therapy concepts in an attempt to expand the parameters of what psychoanalysts call “totalistic” countertransference. Although psychoanalysis and creative art may at first seem quite different from each other, they may indeed have much in common and, in fact, complement each other. Freud himself, in his paper *On The Question of Lay Analysis*, comes to the conclusion that psychoanalysis is, in fact, an “art” rather than a science, and people who are themselves especially creative may be the most particularly well disposed to become psychoanalysts (Freud, 1927). Before I present the major theme of this paper, I would like to define several terms which are often found in psychoanalytic literature, but may be used by various authors in different ways. To ensure that the reader understands my particular usage of these terms, and will, therefore, be better able to follow the reasoning set forth here, I offer the following three definitions.

1. **The Totalistic View of Countertransference**

When Freud first used the term countertransference (Freud), he spoke of the analyst’s unconscious reaction to his patient, based upon the analyst’s early object internalizations. This was, for many years, considered to be a detriment to the psychoanalytic work and such reactions within the analyst would be understood to indicate a need for the analyst to analyze and work through the personal conflicts which stimulated such reactions, as it was believed they would inevitably interfere with the progress of his patient’s treatment. This specific point of view is today called the “classical” definition of countertransference.

However, during the years since this original conceptualization, other authors have written extensively about other types of countertransference reactions which commonly occur in the analyst as he/she works with various types of patients (Kernberg, Masterson, Racker, Robbins, Roland, Searles, Winnicott). These reactions, because of the inevitability of their presence, have led clinicians to believe that less emphasis should be placed upon viewing this phenomenon as the analyst’s deficiency, but should be seen instead as a new and unique tool with which we can better understand the patient’s transference projections and early object, or self-object experiences.

Some authors point out the necessity for the analyst to be open and receptive to these feeling “inductions,” as they inevitably arise in treatment, in order to keep them conscious and not repressed (Masterson, Winnicott, Racker, Bion). It is precisely the repression of such feelings which most often leads to countertransference acting-out, and ultimately to interference with the progress of the patient. This new emphasis then shifts the analyst’s attention onto these “inductions,” rather than away from them, and encourages the analyst to use them to better understand what is happening within his/her patient and therefore plan more effective treatment strategies.

The term “totalistic countertransference” is utilized to include under
"My intent here is to add to the currently accepted range of "totalistic" responses one more kind of response within the analyst." Within this context, projective identification is best understood as a conscious mechanism by which a patient may externalize the self or parts of the self onto the analyst, with the hope that these projections will be received and experienced by the analyst (so the patient can identify with the analyst) but that they will not damage, change or otherwise transform the analyst into either a father or persecutor (Grotstein, p. 126). The key here is that the analyst must receive this projection and in some way acknowledge this receipt. It must then be demonstrated, through behavior, that he/she has not been pathologically transformed by it. In other words, the analyst must allow his/her self to feel it without acting it out in any way. This process then becomes a means to an end for the patient to internalize. It clarifies for the patient the difference between feeling and acting-out a feeling. The analyst must use his/her expanded ego capacity to facilitate this process. In essence the analyst is receiving, transforming, and ultimately neutralizing the pathogenic energy which the patient needs to externalize if treatment is to be successful. This leads the patient to a point where the projection is now somewhat neutralized and more readily available for interpretation and subsequent working through. If any step in this delicate sequence is missed, the patient and analyst may never reach this unconscious material in a way that makes it available for analysis, but rather they would reexperience pathological conflicts through unconscious transference and countertransference acting-out, or find themselves bogged down in a didactic, intellectualized discussion about "feelings." In either case, one must certainly bring the analytic process to a halt.

**Visual Reception** Several authors speak of the necessity for the analyst to assume a position of "passive reception" and become a "container" for these projections (Bion, Robbins, Melzer). This is my belief that the analyst utilizes his/her own inner creative resources by making creative art materials available to both the patient and the analyst during the analytic session, he/she may significantly widen the range of reception of these projections to include visual images. These images must then be used within the session and explored in an open and often playful way in order for the patient and analyst to more fully identify and understand their significance. These images may be treated in much the same way as we treat dream images. The patient must be encouraged to associate to not only the image but, also, the affective experience stimulated by such a powerful phenomenon.

The following clinical vignette is offered to illustrate this process.

**Clinical Example** Miss A. is a 33-year-old artist. She is extremely creative and often uses visual images and metaphors in her treatment to describe feelings which, for her, are difficult to put into words. She began once-a-week psychoanalytic psychotherapy two years ago and, as a result of this treatment, has been able to understand how her current attachment to a boyfriend has, to some degree, a pathologized displacement of split-off aspects of his symbolic representations. This material has been coming through in the treatment as an intellectual, disconnected experience and as a result has not been able to effectively work it through in a meaningful way. She has, therefore, remained a boy friend and guarded and has had difficulty experiencing trust with her (male) analyst.

During the following session the analyst feels this mutual connection and instead of confronting it as a defense (a position taken on many past occasions which inevitably led to a storm), he decides to explore it by sketching spontaneous images on his note pad, as the patient drones. His mental state is one of free-floating awareness as he begins to let his mind roam through the process of affectless words and piece together visual forms. This mental state begins to feel like a sort of meditation. As this process begins to take on a form of its own, the analyst feels this disconnection, but good when you shared your drawing with me, like we shared the feeling of being connected. I'd get a lot more out of this treatment if I'd trust you more. I need to feel that connection in order to trust you.

It is my belief that the analyst's acceptance of this position as the receptacle and container (Bion, Robbins, Melzer), along with his own creative ability to synthesize the projection into a visual image, which leads to this most unusual and productive psychoanalytic experience. Of critical importance here is the analyst's understanding of the projective identification process as being a creative, unconscious communication which is offered by the patient to the analyst, in the service of helping the analyst to better understand her. It was also important in this situation for the analyst to show the patient his drawing. This demonstrated to the patient that the analyst did indeed receive the projection, and was not pathologically transformed by it. It is interesting to speculate whether ongoing reception of such projections would eventually cause the analyst to make a creative way. Any confrontation of the patient's affective withdrawal as purely defensive would have closed off the possibility of this important material emerging. It is both the analyst's acceptance of this position as the receptacle and container (Bion, Robbins, Melzer), along with his own creative ability to synthesize the projection into a visual image, which leads to this most unusual and productive psychoanalytic experience. Critical importance here is the analyst's understanding of the projective identification process as being a creative, unconscious communication which is offered by the patient to the analyst, in the service of helping the analyst to better understand her. It was also important in this situation for the analyst to show the patient his drawing. This demonstrated to the patient that the analyst did indeed receive the projection, and was not pathologically transformed by it. It is interesting to speculate whether ongoing reception of such projections would eventually cause the analyst to make a
The analyst needs to maintain this affective tie in order for the patient to feel understood, and for new object relationships to develop which can then modify the earlier, pathological internalizations."

The analyst may design a variety of interventions, from calmly receiving the projection, containing it and using the knowledge to reaffirm in one's own mind that the overall approach is working, to (on the other end of the spectrum) sharing the image as described above. In fact, for many patients, the analyst's ability to "not respond" may be the most important therapeutic response of all.

One may ask why, in the case above, the sharing was not experienced as intrusive. It is my belief that this kind of intervention will always be, to some degree, a form of acting-out of a symbiotic transfer. However, in this type of situation, it led to more cohesion of her sense of self. Why? The reason is based on a paradox. That is, the patient is best able to relate on a symbiotic level and, therefore, needs to be met on this level. To try to reach the patient in an object related way on a higher level would be, and often was in this case, a hollow intellectualized experience. We needed first to meet in a way in which she could connect and then, through the mirroring of the split-off projection, foster a feeling of cohesion for her fragmented self.

From an Ego Psychological perspective, the use of drawing and clay engages secondary process elaboration and fosters a structure within the ego, which binds instinctual energy, making these images less threatening for both analyst and patient. This "ego mastery" experience takes the primary process energy which until now has had a disintegrating effect on the ego, and transforms it into a structure which can now become internalized, thereby strengthening the ego (Horner).

We must also note the possibility that the analyst's image may spring forth more from his own unresolved personal conflicts than from the patient's own psychic material. In this case we may treat it more as a classical countertransference reaction related with it as such. However, we must also consider the probability that even in such a situation, there is often some aspect of the patient's conflict which sets off the reaction in the analyst, and if we can understand it and not act out our personal conflicts, we may still salvage the situation to the patient's advantage.

A true demonstration of effectiveness of any technique must be judged by the patient's behavior and growth.

Summary

I present to you this material which demonstrates such growth in the hope of expanding analysts' awareness of how they can use certain parts of themselves in a new way to help patients grow. It is not my intention to promote this technique as one which should be widely used without careful consideration of its potential dangers. Like any good clinical intervention, it must be woven into a solid treatment structure which reflects both the analyst's personal and professional skills, along with a healthy regard for and understanding of the where the patient is and what he/she can use. It is always essential for us to assess what a person is or isn't ready to receive such a treatment. The patient's progress was fueled by the power of the experience. Her profound sense of being understood led to a deepening ability to trust, which had a dramatic effect on her fragmented self.

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