# Dealing With Problematic Counter-transference: Supplementing The Solo-Practitioner Model Of Psychoanalytic Treatment By Peer Group "Intervision"

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## Abstract

**To** deal with disturbing counter-transferences a minority of American psychoanalysts utilize either formal individual consultation or peer group consultation (fewer than 20% each). However, both the individual consultant and/or the group leader may have a negative impact on the psychoanalyst's own efforts to develop an individually-suited therapeutic approach. Presumably, many psychoanalysts also rely upon self-analysis which is useful but is significantly limited by the psychoanalyst's own ubiquitous unconscious. We recommend that leaderless "intervision" peer groups be developed similar to those widely used in Germany and proven to be extremely helpful.

## Introduction

We hope that your interest in the topic of this communication may be enhanced by describing our own experiences and how/why we became engaged with this subject. The senior author, J.S., trained at the Columbia University Psychoanalytic Center founded by S. Rado, a Hungarian analyst originally sent from Berlin to be the Education Director of the New York Psychoanalytic Institute. He subsequently became a psychoanalytic radical when he rejected libido theory in the 1950's, thus breaking with the theoretical position of his own institute, the New York Psychoanalytic Institute, and leading him to found the new Columbia University Psychoanalytic Center which was very nearly rejected by the American Psychoanalytic Association. J.S.'s training analyst, a graduate of the New York Institute and subsequently affiliated both with the New York and Columbia Institutes, died unexpectedly at the termination of his analysis. The upsetting loss of anticipated collegial post-termination contact with his analyst led to his critically examining the traditional concept of termination many years later (Schachter et al., 1997).

After graduation, J.S. engaged in empirical infant research studying evoked EEG responses in newborn offspring of schizophrenic mothers (Schachter et al., 1971). Subsequently, he returned to clinical practice, and participated in individual and peer group supervision. He continued his interest in post-termination contact, organized a study group on post-termination contact at APsaA scientific meetings and conducted an empirical study of post-termination contact (Schachter et al, 2001). It was his 2002 book, a critical examination of the concept of transference, that led him, via the study of relational/interpersonal theory, to explorations of how traditional psychoanalysts dealt with counter-transference. His personal peer group experience had impressed him with the limits of an analyst's awareness of his/her own motivations or affective reactions within the specific dyad, and reinforced feelings that analysts need help from others in understanding and dealing with their always to-some-degree-unconscious counter-transferences.

In contrast, the junior author, H.K., began practice later in a German milieu in which psychoanalysts had responded creatively to the federal government and insurance company mandated requirements for quality evaluation of analytic treatment. Leaderless peer group called "intervision" (not "supervision") were created which fulfilled requirements and also proved very helpful in dealing with difficult counter-transferences. We now propose that American psychoanalysts might review that model and consider

developing similar "intervision" peer groups to help them deal with disturbing counter-transferences.

## Freud's Views of Dealing with Counter-transference: The Role of Self Analysis

Freud was aware (1910) "that no psychoanalyst goes further than his own complexes and internal resistances permit …" and recommended self-analysis, though clearly ambivalent about its value. He wrote to Fliess (Nov. 14, 1897) "Genuine self-analysis is impossible" (p.271); while in 1914 he thought "this kind of [self] analysis may suffice" (p.20). Freud himself was never analyzed because he was concerned it might compromise his authority. Later, Freud recommended that analysts periodically undergo re-analysis, apparently reflecting his recognition that analysts from time to time might need external help in dealing with inevitable unresolved complexes and life and practice issues.

## Empirical Study of Counter-transference and Treatment Outcome

Singer and Luborsky (1977) presented a nuanced discussion of counter-transference:

.a) Counter-transference is a hindrance to effective treatment of the patient.
b) Counter-transference hinders the treatment by preventing the therapist from properly identifying with the patient.
c) One of the marks of the occurrence of counter-transference is an inordinate intensity or inappropriateness of sexual or aggressive feelings towards the patient.
d) Counter-transference can be of two kinds, acute and chronic: Acute counter-transference is in response to specific circumstances and specific patients; Chronic counter-transference is based on an habitual need of the therapist; it occurs with most of his patients and not in reaction to a particular conflict.
e) Counter-transference can be a valuable therapeutic tool since it can help in empathizing with the patient.
f) The therapist´s emotional maturity is a deterrent to his potential counter-transference needs which might interfere with the relationship.
g) Avoiding counter-transference problems can be aided by self-analysis or by discussing with a supervisor or colleague.
h) Counter-transference can often be communicated peripherally - that is, through nonverbal cues (pp.447-448).

Kohut, (1984) considered counter-transference inevitably detrimental to treatment, but studies led us to recognize counter-transference may facilitate treatment. Thomä and Kächele (1987) argued that Freud's view of counter-

transference produced “nothing less than a phobic attitude towards one’s own feeling” (p. 82). The authors agree and believe counter-transference can be enhance treatment.

To approach the issue in a more systematic empirical vein Betan and Westen (2009) designed a Counter-transference Questionnaire; they identified five factors :

Factor 1. Overwhelmed/disorganized;
Factor 2. Helpless/inadequate;
Factor 3. Positive;
Factor 4. Special/overinvolved.

Later Hayes et al. (2011) reviewed three meta-analyses utilizing a Counter-transference Factors Inventory consisting of five subscales: self-insight, self-integration, anxiety management, empathy and conceptualizing ability; their most significant finding was that ; *management of counter-transference was associated with better treatment outcomes* (r=.56, p=.000).

**Working in the Counter-transference**

Aron (1991), Blechner (1992), and Renik (1999) recommended a new stance towards counter-transference, “working in the counter-transference”, an approach in which the patient is free to, or invited to, explore the observed personality and psychodynamics of the analyst. While the focus is on engaging the patient to explore his/her own psychodynamics, Blechner also hypothesizes that such discussion may aid the analyst in resolution of counter-transference problems. Frank (2012) agrees, “we simply cannot know all that is going on with us psychologically, and we may be unaware of something that is blatantly obvious to our patient” (p. 319). However, the disadvantages of this approach are later characterized by Aron (1992) who criticizes “working in the countertransference” as somewhat “gimmicky”, and Hirsch (1992), similarly, objects that “working in the countertransference” “is using a projective test without letting the patient know that he or she is being tested” (p. 195). Hirsch adds “The analyst cannot determine what is real and what is not, since unconscious participation is always a factor” (p. 196). An analyst will never be fully open with the patient about his/her inner experience, due to his/her responsibilities to the patient. Blechner (1995) adds that “Consultation with colleagues may also provide an objective opinion about the transference-countertransference interaction” (p. 23).

**Working with Problematic Counter-transferences by Self Analysis**

Since the majority of American analysts fail to utilize either formal individual consultation or peer group consultation (See a Telephone Survey), we presume they use self-analysis and perhaps informal collegial contacts

for help with difficult counter-transferences. Many analysts discuss self analysis, including Kramer (1959), Ticho (1967), Anzieu (1972), Engel (1975), Searles (1979), Calder, 1980, Gardner (1983), Beiser, 1984, McLaughlin (1988, 1993), Anderson, (1992), Simon, (1993), Jacobs (1991), Sonnenberg, 1991 and Chused (1992). Self analysis often involves the analyst's own personal dreams, free associations, symptoms, day-dreams and recovered memories as well as counter-transference fantasies (Frayn, 1996). To date 213 psychoanalytic papers have been written about self analysis (PEP) suggesting that many analysts find self analysis of clinical benefit. However, De Ekboir (1982) concludes "Freud's self-analysis is not repeatable at all. What is today considered post-analytic self-analysis consists of a process of introspection which does not coincide with psychoanalysis proper." (p.81). Chessick (1990) values self-analysis, because "many of my creative ideas for new papers arose out of the free associations in my self-analysis" (p. 330). Another proponent, Consolini (1997) adds that self -nalysis "can enable the analyst to uncover his "blind spots" and do the personal analytic work necessary to prevent these tendencies from impeding the work with other analysands" (p. 61).

**Problems with and Limitations of Self Analysis**

Doubts about the effectiveness of self-analysis may be distilled into the well known comment that "A doctor who treats himself has a fool for a patient". Kerr (2014) described Sullivan's characterization of counter-transference as follows: "all the dynamisms the analyst uses to distance her- or himself from the person in front of her or him, dynamisms that are based on her or his own anxiety." (p.643). While acknowledging that self analysis apparently is useful to many analysts in dealing with this anxiety of problematic counter-transferences, self analysis remains subject to several problems and limitations which constrain its efficacy. Self-analysis is always partial; some insight will always be unconsciously resisted. In the context of the Swedish large scale study directed by R. Sandell, the authors, Falkenström et al. (2007), remark that "The unconscious cannot be switched off by any method of research" (p. 669). Consolini (1997) who utilized self analysis, noted "However, it can also be a tool that, if used improperly as a means of resolving a counter-resistance, will only take the analyst further off course." (p.61). Kantrowitz (1999) described another liability of self-analysis, that "the analyst will prematurely believe in its completeness, and will settle too soon for a partial understanding when something more important still remains hidden" (p. 112). These apparent limitations in the capacity of self analysis to deal with disturbing counter-transferences, supports the utilization of *more than just self analysis.*

Lacan (1959-1960) had proposed the institutionalization of a "third" as a reviewer and interlocutor in routine analytic practice. Frayn, (1996) while valuing self analysis, reached a similar conclusion: "It is important that analysts make arrangements to candidly discuss personal and professional concerns with trusted colleagues, as well as engage in a deeper exploration of themselves within a reflective frame of reference." (p. 305). Kirschner (2012)'s stance is closest to ours, since he suggested that "it may be time, at this moment in the evolution of the analytic discipline, to find new ways to involve others as witnesses to analytic practice" (p. 1239). Although not articulating his recognition of the timeliness, he suggests that "it would not be onerous to involve others as witnesses to analytic practice" (p.1239). He elaborates, that "it would not be onerous, for example, to require candidates to share their work in small groups and practitioners to maintain regular contact with peers as part of membership in a society" (p.1239), thus, coming close to the "intervision" model. He adds, "Perhaps analysts should also consider adopting a formalized practice … which might take the form of periodic meetings during retreats or of institutionalized encounters within regional groupings." (p.1240).

We both agree that while self-analysis is useful the limits of our ubiquitous unconscious have been well documents. Archimedes claimed in his Doric speech at Syracuse, "Give me a place to stand and with a lever, I will move the whole world". We need to recognize that we have no place to stand, no place outside our own unconscious.

**The Need for Consultation with Analytic Colleagues**

The assumption that trained analysts do not need to continue in supervision is, Mander (1993) asserts, a naïve and potentially dangerous self-deception. In agreement with many, Zysman (2012) notes that unconscious interactions between patient and analyst during a session "are beyond the sphere of conscious recognition by the analyst while at work and often also afterwards, so that they call for detailed investigation between sessions and with colleagues as recommended by both Bion and David Liberman" (p.2). Zysman adds, "Caught up in the transference relationship and compelled to struggle with his counter-transference, the valiant analyst clings to his knowledge and to the theories with which he identifies. Although he applies them honestly to the best of his knowledge and belief, this is apparently not all that is taking place, but seems to be just the tip of the iceberg that must be explored" (p.2). The German analyst, Wegner, (2012) commenting upon Zysman's paper, agrees: "If we are to continue to exist as psychoanalysts, we need a psychoanalyst, a patient and a

colleague… that is, ongoing exchanges with colleagues concerning our clinical work." (p.1).

A number of analysts informally share their self-analysis with a friend/colleague who in turn reciprocates with their own self-examination (Kantrowitz, 1999). Sharing the self-disclosure with a friend/colleague who viewed them positively seemed necessary to optimize benefits. These relationships may be categorized as mutual supervision and Silber (2003) gave a clinical example of his once a week mutual supervision. with an analytic peer on the telephone. He described a male patient of his who maintained a masochistic position with his wife. His supervisory peer helped him recognize that he, Silber, was maintaining his own masochism by identifying with his patient. Silber had never been enabled to accept his own aggression in his two training analyses, but when he became angry with his supervisory peer partner, he was able to recognize and accept his own aggression.

## Psychoanalytic Education Prescribes The Solo Practitioner Model of Psychoanalytic Treatment

Training analysts in particular, and supervisors to a lesser extent, in their therapeutic and educational roles, constitute authority figures who personify the solo practitioner model, and, by implication, how to deal with their counter-transferences. Rado (1956, [1934-1937]) made a prescient observation 80 years ago that analytic training "hastened to patronize and to overawe the student rather than to foster his intellectual independence … it has not impressed upon him the fact that only by means of his own independent thinking can he properly assimilate what he is taught … That training is a failure which accomplishes no more than to make the student believe that his role is blind belief" (p. 125). Schlessinger (Katz, 1995) believed that one learning problem for candidates was "identifying with their own analyst, with the insistence on doing things only in the way the personal analyst did" (p. 245). Kernberg agreed in a series of papers on the same theme, culminating in one published in 2010 and repeated in a presentation to the American Psychoanalytic Association (2013) confirming candidates' identification with their training analyst. Subsequent research supports these observations since graduate analysts report practicing very similarly to the way their training analyst practiced (Schachter et al. 2013), i.e., as solo practitioners. An ancillary finding confirms the salient uniqueness of the training analysis; approximately 80% of candidates remain in training analysis until reaching a mutually agreed termination (Schachter et al. 2013), whereas, ordinary, non-candidate patients drop out of analytic treatment in approximately 50% of treatments. We hypothesize that non-candidate

patients, lacking professional attachment, view analysis more pragmatically and critically than candidate patients whose careers are also at stake. Supervision also has a singular impact, and like Rado, Levenson (1982) asserts that "the function of supervision is essentially to supply the supervisee with an algorithmic approach to the analytic process (p.6). He adds "I'd like supervision not to encourage the therapist's submission to superior wisdom or skill" (p. 8). The supervisor, he suggests, should indicate to the therapist that "every time he interprets he is taking a position about the material, that this is only one of many positions that can be taken about it, and this position represents a participation with the patient which is both isomorphic or resonates to the patient's life experience but also comes out of who the therapist is and what his real life experience is" (p. 12).

Aron (1999) makes the same point: "How can we say to a trainee that this is what *the* psychoanalytic response should be in a given situation, that this is *the* proper psychoanalytic intervention, based on *the* standard or model psychoanalytic technique, when we and the student know that there are any number of other analysts and supervisors, often in the same institute, who would disagree and do things differently" (p. 3). Graduate solo practitioners may remain unaware that some of their colleagues may have different conceptions. "Maturation as an analyst," writes Schaffer, (2006) "therefore, requires a self-supervisory grappling with the differences between the analyst's internal sense of what is curative and publicly held theories of therapeutic action" (p. 351). Kerr (2014) reports that "Sullivan … repeatedly insisted that his own devices are what worked for *him,* i.e., they were suited to his personality. Other therapists had to use what worked for *them*, he said, utilizing the interpersonal skills *they* had picked up through living." (p. 653). Paradoxically, analysts may need help in determining what works best for them.

The solo practitioner, attempting to deal with troublesome counter-transferences through seeking help with an individual consultant or with leader-run peer group supervision, faces the risk that the consultant/leader's expertise may trump the development of an individual approach to exploring and dealing with counter-transference liabilities. Kantrowitz (1992), realized she was having a counter-transference problem when she ended a patient's session 10 minutes early, and she sought individual consultation. The consultant suggested that the following interpretation be presented to the patient: "You were doing something well yourself . Something made you stop. Let us try to see what you found so intolerable that you threw up your hands and hoped someone else would take over." Kantrowitz presented this interpretation to the patient repeatedly, and reported that the patient was able

to utilize it and subsequently terminated with a new-found sense of competence and confidence. In this example the consultant provided his/her own interpretation for the patient, but did not help Kantrowitz explore her counter-transference difficulty dealing with the patient. Kantrowitz's counter-transference problem apparently remained unaddressed and we do not know if it had negative consequences for the patient's treatment.

**Resistance to Changing the Solo Practitioner Model of Psychoanalytic Treatment**

One factor, which we're inclined to weigh heavily, is that solo practice was Freud's own personal psychoanalytic model and this model has been perpetuated in our educational institutions for more than one hundred years. Deviation may seem too difficult, risky, even threatening, to many analysts in their current environment. Freud's Wednesday Group meeting was not a forum for discussion of troublesome or stalemated treatments by the members.

We think historical and cultural factors also played a role in the failure of individual analysts to consider modifying their traditional model of isolated solo psychoanalytic practice. The residual values of an early American frontier culture which idealized the qualities of independence and autonomy probably played a role. Lazarus (Moran, 2012) points to the original and still current medical model of psychiatry and psychoanalysis in which the physician operated primarily as a solo practitioner. Early male dominated psychoanalytic history emphasized these values, which also influenced conceptions of termination of psychoanalytic treatment in that patients were expected to become so autonomous that there'd be no further need ever to re-contact the former analyst. Mahlerian theory also places a premium on separation and individuation.

An early theoretical factor contributing to supporting isolated solo practice was the educational prioritizing of the one-person model of psychoanalysis, in which the psychoanalytic process was conceived as taking place in the patient's mind (Rangell, 1968). Further, the neutral, abstinent analyst minimized interaction with the patient, thereby reducing awareness of the effects of the analyst's counter-transference. Consistent with this is the fact that from 1900 to 1965 Psychoanalytic Electronic Publishing (PEP) reports a total of 74 papers on counter-transference, an average of only 1.1/year. Later, from 1935 to 2000, there were 578 papers on counter-transference, an average of 8.9 papers per year. Although there was some increase in the population of analysts in the later 65-year period, this alone cannot account for the large increase in the rate of publishing papers on counter-transference in the latter period, which may well reflect a

changing patient population and the growing acknowledgement of the significance of inter-subjectivity and the effects of the analyst's reactions.

Further, we consider that a shared enthusiastic analytic narcissism may have contributed to a belief in analytic "cure": that successful, training analysis – or any analysis - should sufficiently enable the patient/analyst to deal alone with the stresses of a long career. Many analysts' strong convictions about the efficacy of psychoanalytic treatment and the intense confidence in the psychoanalytic theories and practices they had been taught might conceal the disorder that Jonathan Lear (1998) has termed "Knowingness": a *defensive* reaction of super-confidence to underlying ambivalence and doubts about the validity of analytic theories and practices. Analysts may try to protect their authority and confidence by avoiding considering a need for help from colleagues.

## A Telephone Survey on the Use of Consultation By Members of the American Psychoanalytic Association

Two hundred members' names were selected at random from the Roster of the American Psychoanalytic Association; 20 phone numbers were not responsive. Each of the remaining 180 were queried by phone by J.S. using a script: "(1) Are you in active practice? (2). During the last six months have you utilized either no consultation, or a formal individual consultation and/or peer group consultation. Please call at 212 787 4270 and leave an anonymous response. For a representative result, it is important that, whether or not you are in active practice, you respond".

Response rate was 42% of 177 responsive phones of those in active practice; three were not in active practice. Individual consultation was reported by 19%; peer group consultation was reported by 18% (including six respondents who reported both). Twelve respondents reported neither individual nor peer group consultation. Fifty-eight per cent of the analysts with responsive phones were non-responders. Why were they not willing to respond by making a phone call? Possibly, opposition to research as Russell (2014) describes. In addition, we can speculate, without evidence, that many of the non-responders may also have utilized no consultations, but may have been reluctant to acknowledge that they do not use consultations because they may have felt a negative value judgment about their not utilizing either individual or peer group consultation, (the way analysts with few or no analytic patients did not respond to official APsaA practice surveys) and avoided acknowledging that by not responding. In addition, some may not have responded because they were no longer in active practice.

## Leader-run Supervisory Groups

A clinical example of a Bionian approach is an example of a leader-

run consultation group that was helpful to a troubled case-conference organizer (Burka et al., 2007).

The Balint groups warrant mention because both of similarities and differences to "intervision" groups. They are organized with 8-12 general practitioners and one or two psychoanalyst leaders who meet once a week for two hours to discuss patients in their practices currently presenting difficulties. E. Balint describes the work as, "amassing facts and the feelings about the facts at the same time [and] we are now more observant of *changes*, however minute, which take place in the doctor/patient relationship – in the doctor's feelings about his patient – and in the patient's complaints" (1985, p.3). E. Balint believes the work provides "a moment of mutual understanding between a doctor and his patient which was communicated by the doctor to his patient." (p.6). Since the groups have psychoanalyst leaders, Kutter (2002) concludes that "The Balint method and psychoanalytic supervision are therefore synonymous" (p.321).

Marshall (1999) polled the members of two leader-run supervisory groups to discern what they thought helped a group function cooperatively. Five overlapping variables emerged: (1) mutual acceptance and support; (2) play; (3) tolerance and enjoyment of primary process; (4) resolution of intra-group conflicts; and (5) gained competence.

**'Weaving Thoughts'; A Peer Group Consultation Concept**

This unique 10-15-member group which eschews selected leadership aims to create a framework for presentation of clinical case material modeled on an analytic session. One member presents details about one analytic session plus the age, sex of the patient and the date the treatment started; the presenter neither discusses the presented material, responds to questions, nor provides further background material. The moderator remains abstinent from any recommendations, and recognizes members who wish to comment and sessions end with no effort made to tie up loose ends. Two patients presented by Norman and Salomonsson (2005) were further discussed by Salomonsson (2012). Norman and Salomonsson also described problems that may develop in the group: elitism and the building of factions in the group; interrogation of the presenting analyst; narrow-mindedness in the discussion; authoritarianism towards the presenter and group members; belief in authority among group members; competitiveness among group members; helplessness of the presenter or of the group; idealization of or by the group.

Traditional analytic theory assumes that analytic process takes place in the patient's mind (Rangell, 1968). Modeling this conception of "Weaving Thoughts" on the traditional analytic session seems an attempt to

apply a traditional theoretical view to the actual process in these group sessions; alternatively, relational/interpersonal theory, which hypothesizes that analytic process takes place in patient-analyst interaction, would develop a different group process.

## Supplementing the Solo Practitioner Model: Peer Group "Intervison"

The American Psychiatric Association's presidential address in November 2012 by J. Lazarus described the future of American health care in which physicians, including psychoanalysts, will need to collaborate with other specialists into a new model of integrated care (Moran, 2012). Lazarus recognized that integrated care requires a change in the core values that have traditionally motivated physicians from autonomy and independence to shared decision making and teamwork. Leaderless "intervision" groups offer a most promising possibility of collegial help with counter-transference problems.

The postwar German psychoanalytic solution to the joint requirements of the German government and insurance companies for the repeated assessment of quality control of analytic treatment is a unique form of confidential professional external evaluation and help, *leaderless* peer group "intervision". The term, "intervision", was chosen to distinguish it from leader-run peer group "supervision", and respect for individuality of the treatment remains the principle for all members of the group. Since peer group "intervision" has *no leader* the participants maintain that hard-earned "peer" status which may be lost when the analyst turns to an expert consultant/leader for help. Further, with peer group "intervision" no money changes hands.

By 2000, Stehle was able to report that of 657 German analysts in private practice 85% regularly take part in some form of clinical continuous education while some 9% refuse and 6% participate intermittently. Those who participate regularly register on average for 23 peer group "intervision" sessions per year; younger member analysts continue their formal obligation for supervision. The remaining 539 analysts, register on the average for 20 peer group "intervisions" per year.

Quinodoz (2013) suggested that elderly active psychoanalysts be asked to participate in leaderless "intervision" groups where they could talk about their patients: "By ending the analyst's solitude, these intervision seminars would form a convivial meeting-place that enabled elderly psychoanalysts to share their experiences with younger ones … it could also be a supportive place in which they could become aware of the state of their professional capacities" (p. 796.)

A personal description of participating in an "intervision" group is provided by a participating German analyst, Schunter, from the Ulm group (Hansjoerg.Schunter@bn-ulm.de) has been translated and edited freely:

"The topic of "intervision" has kept me in its grips for the last 30 years and I have participated in my recent group, composed of experienced colleagues, for more than ten years. Let me extract from this experience the conclusions I have reached:

Ideally group size should be 4-6 with fairly regular attendance leading to the liveliest case discussions. Voluntary participation continuity provides benefits to all participants in their professional as well as private lives. While the composition of the group is optimal when most of the colleagues share similar years of experience, younger colleagues can be integrated and will absorb the culture of the group. Personal vanities and narcissistic vulnerabilities decrease in the longer exchanges; however occasionally a member disappears as a result of feeling too criticized. We are aware that working together for long times in such groups may create a danger that the critical potential is reduced if everyone becomes too accustomed to the others' ways of thinking; then at those times it has been useful to invite an outside guest from time to time".

A more personal supplementary statement is provided by the President of the German Psychoanalytic Association (2012) Walker (christoph.walker@t-online.de), a member of a Tübingen group:

"Basically I couldn´t imagine my work as psychoanalyst without the collegial exchange in "intervision" groups. The group I am most committed to consists of four members, two women and two men and has met weekly in the early afternoon for the last 22 years.

I consider that the most relevant aspects are a stable, reliable frame which supports the growth of confidence among us. In this atmosphere we can cultivate a readiness to talk about what is really difficult in spite of all the associated negative affects. This enables members to be confronted with "one´s blind eye" without shame and devaluation. Members are encouraged to remain curious and the change from presenting one's own case material to listening to others' cases increases awareness of both knowing and not knowing, and enables the communication of the uncomfortable. The group is a container which enables exploration of the analyst's frustration, of what has changed, and also of what was not present in analysand or analyst. The collegial relationships enable explorations and changes of clinical and theoretical concepts".

The authors know of at least three ongoing leaderless peer groups in the United States; one such group of six analysts has been meeting weekly

for 32 years! One report of an American leaderless consultation group (Hunt & Issacharoff, 1975) did end with an unsatisfactory outcome. Eleven group therapists met bi-weekly for about three years to discuss their experiences and problems in group therapy work; counter-transference emotions were discussed openly. Supervisory comments were characterized by an accepting 'supportive' attitude, and the joint effort was felt to be something quite precious. However, the initial task of the group gradually gave way to an examination of the process within the group, and still later, members decided they wanted therapy through the group process. This led to repeated failures to follow through on that decision, and at the end of the group's third year a rotating leadership from within the group also failed. When they sought a leader from outside the group, the chosen therapist declined accepting a leadership role because of a judgment the group was not sufficiently motivated for therapy. After this rejection the group dissolved.

Another illustration of an American "intervision" clinical experience (Betan and Westen , 2009) conveys a typical clinical experience: "*From the start, patient Mario 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.*

*Interpretations of Mario's need to control the interaction and fears of difference, along with attempts to articulate the therapist's understanding of the links between his 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". Mario's therapist needed to find*

*space to think her thoughts, to reflect on her feelings of dread and anger, and to recognize how APsaA members [of the "intervision group"] turn her attention to considering how her experience of feeling controlled and invisible might provide hints to understanding Mario's internal experience of himself and his relationships. These reflections on her counter-transference reactions could be a means to empathic connection with Mario's early experience." (p. 192).*

## Conclusion

Inevitable counter-transference problems may interfere with optimum therapeutic benefit. A few analysts utilize informal mutual supervision with a trusted friend/colleague who they know provides the safety of positive regard. Both individual consultation/supervision and leader-run peer group supervision may be helpful but risk imposing the consultant/leader's conception of treatment upon the analyst seeking help. Our telephone survey of APsaA members indicate that formal individual consultation and peer group consultation are each utilized by a minority of responding members (less than 20% each). Presumably, the majority of American analysts rely primarily upon self-analysis to help them deal with troublesome counter-transferences. While self-analysis may be helpful, its efficacy is limited by our acknowledged dearth of access to many of our unconscious feelings and fantasies.

In contrast, German analysts make widespread use of culturally and insurance-supported "intervision" leaderless peer groups. They report it to be extremely helpful in dealing with clinical problems and disturbing counter-transferences. The continuing ongoing leader-less structure helps maintain the peer status of all the analyst participants. The reported functioning of three "intervision" peer groups is described briefly and the names and email addresses of one member of each of two groups is provided to offer help and guidance to analysts interested in creating new "intervision" peer groups.

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