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COUNTERTRANSFERENCE AND ITS POTENTIAL FOR ABUSE

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ABSTRACT: The definition of countertransference ranges from pathological and inappropriate responses of the psychotherapist/psychoanalyst based on inner issues and conflicts (hence an obstacle to cure) to a position that countertransference feelings and reactions provide useful information in understanding the patient and contribute constructively to the curative process. This later definition can enhance and expand the analytic inquiry. However, with this expanded conceptualization, abuses of countertransference can have damaging impact on the patient. This presentation will undertake to explore one aspect of such abuse and speak to the specific influences that contribute to the misuse of countertransference in the therapeutic situation.

A brief review of the literature on countertransference is offered as background. Orr (1954), Kernberg (1965), and Langs (1976a) have developed in depth an historical overview.

Freud referred to countertransference in only two of his published works. He introduced the term in his 1910 paper, "The Future Prospects of Psycho-analytic Therapy." Freud used adjectives of admonition and caution as he addressed his colleagues. "We have become aware of the 'countertransference,' which arises in him [the physician] as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize this countertransference in himself and overcome it" (1910, pp. 144-145).

Freud's second reference to countertransference appears in his 1915 paper on "Observations on transference—love." The male physician is warned to maintain his neutrality in the face of transference love by his female patients. Indeed, Freud (1915) states that "neutrality towards the patient, [is] . . . acquired through keeping the counter-transference in check" (p. 164). Thus we can discern a view of countertransference as disruptive, undermining neutrality and impinging on the therapeutic

process. Additionally, Freud recommended periodic return to analysis by the analyst, suggesting that countertransference issues are an anticipated risk in the profession. The implication is that an analyst is morally bound to return to psychoanalysis to avoid damage to patients (Freud, 1937).

It took more than thirty years before Freud's position on countertransference was effectively challenged.

Ferenczi's (1920) notion of reparenting the patient, Balint's (1939) vision of the inevitability of intrusions of the analyst, from the smallest detail in office decor to the manner of interpretation, and Sullivan's (1953) conceptualization of the analyst as a participant in the therapeutic process ushered in the seminal contributions of Heimann, Little, Winnicott and Racker. These theorists had dramatic impact on the classical vision that countertransference was a hindrance to the analytic task. They expanded their belief that countertransference feelings and reactions by the analyst in the therapeutic situation, could be used as a source of information and offer potential value to the analytic treatment.

Paula Heimann's (1950) four page article boldly and concisely articulates the theme that will be expanded on by other theorists. "My thesis is the analyst's emotional response to the patient within the analytic situation represents one of the most important tools for his work. The analyst's counter-transference is an instrument of research into the patient's unconscious" (p. 81). Thus Heimann frees herself from the prevailing view that countertransference is "bad." Additionally, she expands the definition of countertransference to include all the analyst's fantasies and feelings about the patient. The analyst's valid non-neurotic experiences of the patient were considered under the rubric of countertransference as contrasted to the more narrowly defined and classical definition of countertransference as referring only to pathological related experiences and responses. Kernberg (1965) identifies this formulation as a "totalistic" view of countertransference. Heimann makes the recommendation that the analyst should not communicate countertransference feelings to the patient, but use countertransference feelings as a source of insight into understanding the patient's psychodynamics. She admonishes the analyst that "to communicate one's feelings to the patient . . . is more in the nature of a confession and a burden to the patient" (p. 83).

Winnicott's (1949) paper "Hate in the Countertransference" made a fantastic leap beyond the current theories. He introduced the term "objective countertransference" as he distinguished between the analyst's neurotic responses from the "analyst's love, and hate in reaction to the actual personality of the patient, based on objective observation" (p. 70). Winnicott focused on a type of expectable response and reaction to very

disturbed patients. He introduced the radical notion that when the analyst's intense countertransference feelings are "objectively" induced, it could be advisable to offer feedback to the patient for the dual purpose of meeting maturational needs of the patient, and enabling the analyst to endure and carry on the treatment.

Margaret Little (1951, 1957) developed the concept that the analyst's countertransference was central to the work with the more severely disturbed patient. Little was exquisitely sensitive to the unconscious communicative interaction between the analyst and the patient. She put forth the concept of the influence of countertransference based errors and also believed that the analyst's self disclosure of countertransference feelings could have a curative impact on the patient.

Heinrich Racker holds a unique position in the expanding conceptual development of countertransference. This South American psychoanalyst produced a number of papers between 1953 and 1958, later collected in his *Transference and Countertransference* book in 1968. His papers are grounded in a powerful conviction of the importance of the interactional aspects of countertransference. Racker develops a clear, concise classification of expectable countertransference reactions to specific transferences of patients. He felt that the totality of countertransference reactions, even if dominated by the analyst's pathology, could offer significant information about the patient. He speaks to the "personal equation" or the unresolved neurotic issues that impel the analyst to respond transferentially in the analysis (1957, p. 303). Paralleling the transference neurosis development of the patient, is the countertransference neurosis of the analyst which occurs when the patient's projective identifications induce the analyst to experience his patient in a "complimentary" manner. An example of this would be a superego, critical experience by the analyst to the patient's promiscuity.

A second process can be set into play, revolving around the analyst's empathic responses and in identification with the patient's feelings and thoughts. However, Racker remained very cautious about relaying the analyst's countertransference feelings to the patient. In fact, he advised, "we need extensive and detailed study of the inherent problems of communication of countertransference" (Racker, 1968). Ultimately, Racker states that countertransference reactions cannot be avoided: "We are still children and neurotics even when we are adults and analysts" (1957, p. 303).

However, disagreement prevailed on how the countertransference information was to be used. Could any of this data be disclosed to the patient? If so, what kinds of countertransference experiences and responses should be expressed? Gitelson (1952) recommended communicating countertransference feelings only when necessary in furthering the analytic inquiry; but how did one define what would further the

analysis? Some analysts, particularly those who worked with the more disturbed patient, appeared to be practicing self-disclosure in selected situations (Little, Winnicott).

One eloquent classical theorist rose to respond to the challenge to the prevailing theory. Annie Reich (1951, 1960) offered a reaffirmation of the Freudian position on countertransference. She rejected the notion that countertransference could be used as a therapeutic tool and passionately expressed her opposition to the views held by Heimann, Little and Racker. Reich put forth a litany of countertransference pitfalls ranging from sexual and phobic to narcissistic and paranoid attitudes. She advocated that the analyst must stay "uninvolved" and maintain neutrality (1951, p. 25). Empathizing with a patient was considered expectable, but all intense countertransference reactions were considered by definition pathological and evidence of countertransference impingement. Reich rejected the notions of predictable or objective reactions to certain patients as well as any circumstances where self disclosure would be helpful. Indeed, she felt it would be a burden to the patient and would interfere with transference development. Finally, she sums up her position in the following statement: "The countertransference as such is not helpful but the readiness to acknowledge its existence and the ability to overcome it is" (1960, p. 392).

The shifts in understanding countertransference emanated from several quarters. The expanding understanding of transference developed the appreciation of the subtle attempts on the part of patients to induce and provoke in a concealed manner repetitions of past relationships. This followed with the understanding of the subtle and sometimes unconscious internal experiences of the analyst. These theoretical developments highlighted the interactional or interpersonal dimensions of transference.

In addition, psychoanalysis and psychoanalytic psychotherapy increasingly became the treatment of choice for the more damaged patient with poorly organized personality structures. The attachment to the analyst, an emphasis on taking in from the analyst in the analytic process replacements for unhealthy aspects of experience, challenged a vision that interpretation and making the unconscious conscious, single handedly effected therapeutic cure. The concept of the analyst as a therapeutic instrument in the interaction with the more damaged patient held more centrality to the analytic process.

There appeared to be a "democratizing" of the analytic situation (Epstein and Feiner eds., 1979) by interpersonal theoreticians. Sullivan (1953), expounding a more American anti-authoritarian attitude, spoke not only to the fallibility of the analyst but to the analyst's active participation in the analytic process.

Scientific data highlighted the impact of the observer on the data, funneled down into psychoanalytic theories. Indeed the therapist was becoming humanized and the classical view of the analyst as a "blank screen" or "mirror" (Freud, 1937) was coming under constant attack. The analyst's personality and responsiveness blurred the concept of the "blank screen" (Gorkin, 1987). In fact, the implicitly held notion, that anyone who underwent a training analysis was a possessor of superior mental health was questioned. Fromm (1947), not unlike Freud's position, advanced the notion of the analyst's life long need for self analysis.

In summary, some theorists moved from a model of suppressing the self in the therapeutic situation to a vision of analyst and patient as co-participants in a viable, vibrant emotional experience.

Greenberg and Mitchell (1983) describe the distinction between the classical theoretical model and relational model of countertransference. In the classical model, countertransference comes into play when unresolved neurotic conflicts in the analyst rise in response to the patient's particular characteristics. Thus, events in the analysis are seen as pre set and unfolding from "within the dynamic structure of the patient's neurosis." The analyst can be cast in a series of roles derived from the patient's past relationships and parts of the patient's self, in both theoretical models. However, the crucial difference is that the analyst in the relational construct can "never function outside the transference" (p. 389). Succinctly put, the analyst serves as a co-creator of the transference as his/her personality, behavior and attitudes have significant impact on the therapeutic encounter with the patient. Countertransference is therefore an "inevitable product of the interaction between the patient and analyst rather than a simple interference stemming from the analyst's own infantile drive-related conflicts (p. 389).

The new advances in the use of countertransference have given rise to the potential of destructive application. Freed from the constraints of classical neutrality, the misuse of the analyst's countertransferential feelings has loomed as more prevalent in today's psychoanalytic arena.

It is quite possible the notion of "tabla rasa" and "blank screen" could prove, at times, sterile and unproductive but the abuse of the therapist's induced countertransference feelings can have more overt potential of inflicting emotional damage to the patient.

Undoubtedly, the expanding theoretical and clinical development of the concept of countertransference has offered the analyst a significant tool in understanding the variegated complexities of the psychic life of the patient. It can be used to exquisite advantage and enhance the richness and the breadth of the psychoanalytic inquiry and experience. However, it can also be sorely abused.

The following clinical vignette is presented to demonstrate an ex-

ample of misuse of the analyst's experience of induced countertransference feelings. This example is offered as a possible prototype of this kind of abuse.

Marianna, a 28-year-old unmarried speech therapist, entered treatment with the presenting problems of feelings of loneliness, depression and hopelessness. She had struggled with anorexia since the age of 15. Although this was now under better control, she feared her resolves being undermined. She felt she was stuck, as life consisted of going to work, having dinner with a friend once a week, and a movie with another friend every Sunday. This description appeared to be the breadth and rhythm of her activities. On direct questioning Marianna informed me that she had been in analysis for three years with the frequency of three times a week. She stated the analysis ended the previous year by mutual consent when she reached a therapeutic goal of leaving a place of employment where she was emotionally abused by a sadistic and critical supervisor.

I was struck by Marianna's appearance. She dressed in pleated skirts and white blouses, reminiscent of the uniforms worn in parochial schools, which indeed she had attended. She was quite tall, slender, with a boyish figure, but her stooped over posture reduced her height. On the occasions that eye contact was made, she looked terrified and quickly averted visual connection. Marianna would literally dart into the office, sit down and maintain a rigid and still posture throughout the session. Her body language seemed to exude vigilant watchfulness, as she surreptitiously glanced at the analyst, attentive to her every movement and reaction.

Marianna's history presented a picture of a battered child both emotionally and physically. Her father, a successful salesman, was apparently an alcoholic, who seemed to single out his oldest daughter as a focus of his abuse. Her mother was terrified of Marianna's father and offered no protection. Physically, Marianna was at least five inches taller than her three younger sisters as well as the only redhead.

She was bombarded with epithets such as "stringbean", teased that she was the result of "the hospital making an error", and that "no man would want a woman with a boy's body." Her father would derisively comment that she was the closest thing to getting the son he always wanted. The patient said that any assertive comment was greeted with verbal assaults and being smacked in the face for having "an attitude." She quickly learned to say very little and to attempt "perfect behavior."

However, Marianna had one outstanding quality which supposedly her father begrudgingly admired. She was endowed with exceptional intelligence and achieved high grades in both parochial elementary and high school. The administrative nuns urged her father to let her go to a local parochial college on a scholarship. She excelled in her scholastics, received a doctorate and trained in a branch of neurological speech therapy that is quite lucrative and in demand in the workplace.

This woman, with such evidence of poor self-esteem, sexual confusion (she had two abortive and destructive sexual encounters), uneven development, and glaring interpersonal problems presented such a damaged picture that I had difficulty understanding how her former analysis could be terminated by "mutual consent."

Eight months into treatment, when clearly there was beginning evidence of a sense of trust and safety evolving, she spoke of her former sadistic employer and the difficulty she experienced in this relationship. As this event occurred

during her last therapeutic experience, the analyst shifted and encouraged her to talk about her experiences with her former analyst. In the past, Marianna would get evasive and defensive when this topic was broached. She apparently did not feel safe enough to expose some of her deeper and more painful feelings.

On this occasion, however, Marianna said she was really "a loser" like her father said. In fact, her former analyst (supposedly in the context of why she does not attract men) said, "I can understand why that occurs because I experience you as boring." Marianna was adamant that this was a direct quote, stating it was etched in her memory. Termination occurred one month later.

Marianna broke into intense sobbing, filling the room with a palpable despair as she spoke of her father, her former supervisor and former analyst as one. Her pain was wrenching and after several minutes of sitting quietly with her, the analyst said that when someone is terrified of not surviving both physically and emotionally, the safest posture is to retract into a cocoon, hoping to be the smallest target possible for the attack. Yes, that could be seen as not very exciting but, after all, she achieved her task of survival.

Her reaction to the analyst's intervention was dramatic. Her body seemed to literally soften and relax and as her sobbing ebbed, the most ingenuous little smile crept on her face.

Did the episode with Marianna's former analyst occur or was Marianna's formulation a result of transference distortions? If it occurred, the question that is posed is, what was the therapeutic value of that intervention? Several possibilities come to mind. Marianna's characteristic constellation of defenses are quite deadening and her progress in treatment is inexorably slow. Would the former analyst's intervention act as a derailment, a means of interrupting the "stuckness" of Marianna's characteristic posture? If Marianna perceives her impact on others, would it make a significant change in her behavior?

However, Marianna may induce sadism in others and the former analyst's response could have been a collusionary reaction to her masochism (Langs, 1975). Was it an example of Racker's description of a "complimentary response to the patient" (Racker, 1957)? If this is the case, it could have duplicated in reality the noxious parental introjects of Marianna and be of negative therapeutic value. Marianna's experience seemed to indicate this was the case.

This clinical example demonstrates what I believe is an abuse of the analytic use of the concept of countertransference. I suspect, for a variety of reasons, there is an increase in this kind of abuse.

The shift to underscoring the importance of a relational frame particularly with the more damaged patient, places the quality of the patient's relationship to the analyst as a central focus and an important determinant of analytic cure.

Indeed, Merton Gill makes a forceful statement: "I have suggested a redefinition of transference. The definition would change from the customary one of transference as a distortion of reality defined by the analyst to a conception of a transference-countertransference transaction in which

from the differing perspectives of patient and analyst each has a view which has its plausibility" (1983, p. 234). The role and function of the therapist shifts with these reformulations and has important implications.

Ferenczi (1921) advocated an "active caretaking response;" Fairbairn (1952) stated the analyst needed to become a "good object" as a prerequisite to the patient relinquishing ties to the bad object; Winnicott (1949, 1960) recommended an analytical unconditional acceptance (in the facilitating and holding environment) and highlighted the importance of the therapeutic relationship in the patient's differentiation of fantasy from reality; Levenson (1972) had the vision that cure is effected by the dialectical interaction of the patient-therapist dyad and Kohut (1977) emphasized the centrality of the analyst's empathy vis-à-vis the patient.

With the widening scope of psychoanalysis and the inclusion of the more damaged and disturbed patients coming under its purview, we see a potential of greater and more intense countertransference reactions in the analyst.

Indeed, patients in diagnostic categories seem to generate some expectable as well as idiosyncratic responses which are partially a function of the character structure and/or the particular emotional state of the analyst at the time.

The borderline patient can flood the analyst with a profound intensity of affects, and these affects can dramatically flip-flop within the course of a single session. The therapist is often left feeling confused, not knowing how to predict the patient's behavior, let alone be able to identify and deal with the chaos and the intensity.

Then we have the narcissistic personality who defends against the relationship to the object. This often takes the form of cutting off affects to defend against the connection to the other. The defense of grandiosity is often seen, as it supports the illusion that nothing is needed from others thus creating a feeling of irrelevancy and unimportance in the therapist. Modell (1975) states the "analyst . . . continuously in the presence of another person who does not seem to be interested in him, or indeed acts as if he was not there, . . . may experience this as an affront to his own narcissism and may accordingly become bored and sleepy" (p. 275).

The psychotic patient primarily fixated at the prementational phase and whose psychic organization is quite primitive, can and does evoke the most disturbing countertransference and defensive reactions in the therapist. The therapist can become confused, agitated, off balanced, intimidated and fearful.

Bion (1970) points out that with the sicker patient, the analyst is far more than a screen for projections. The more damaged patient uses the analyst as a container of projective identifications and attempts to provoke the analyst into behaving like his own internalized world.

These processes sharply demonstrate the fluidity of ego boundaries which can be a bombardment on the emotional life of the analyst. Indeed, Winnicott (1949) talks of detoxifying intense countertransference feelings so as to be able to continue in the therapeutic relationship in a constructive manner. The potential for confusion and intense countertransference reactions is evident.

My experience as a control analyst has demonstrated the understandable difficulty analysts in training have with the more disturbed patients. The patient's fluidity of boundaries and internal confusion and conflicts are often expressed symptomatically as being unable to maintain the analytic frame (keeping appointments, being on time, paying for sessions). This behavior sorely tests the therapist.

Adding to the difficulty is the patient who expresses unpredictable rages and excessive neediness, often in the form of out of sessions telephone contacts and attempts to shift and expand the time frame of the sessions.

The analyst in training, often not well versed in resistance analysis, makes major efforts not to lose patients, often accommodates to the array of patient's inappropriate requests with the belief that it will hold the patient in treatment. This behavior often leads to misalliances (Langs, 1976a).

The chaotic patient is sometimes attacking, treating the therapist as he has been treated. The analyst in training is in the process of building up a professional sense of self. There is often a struggle to develop self-esteem and a sense of competency in what often feels like an overwhelming task of mastery of massive amounts of theory and the need to integrate theory with clinical skills. On top of this are simply the idiosyncratic countertransference issues of each therapist.

Clearly the more damaged patient creates a fertile field of intense and potentially painful countertransference feelings. How are feelings of impotence, loss of control and a sense of inadequacy counterbalanced? A variety of responses by the therapist may occur. Excessive gratification in the form of anticipating needs, infantilizing and not setting limits, can give the therapist a feeling of strength and encourage the patient to see the analyst as all powerful and all knowing. Ultimately this is quite destructive as it often duplicates the original transference of an omnipotent intrusive parent.

The myth of the well analyzed analyst who is responding to induced countertransference emanating from the patient is indeed a seductive trap. To repeatedly point to difficult, off putting defenses and character styles of a patient, implying a justification of a non-therapeutic response, is at best non-professional or, at worst, destructive. The classical theoretical model which may have been too self-limiting and rigid did offer a containment of control and restraint with its negative vision of countertransference.

Margaret Little (1981) states: "The very real fear of being flooded with feelings of any kind, rage, anxiety, love, etc. in relation to one's patient and being passive to it and at its mercy, leads to unconscious avoidance and denial" (p. 149).

The total exclusion of a classical vision of countertransference in favor of possibly a more comfortable stance that one's emotional reactions are exclusively or primarily induced by patients, must be examined. We need to embrace a notion of a never ending working through process of our psychic issues.

Abuse of countertransference reactions does not alter the intrinsic value of psychoanalysis as a treatment modality. However it highlights the importance of self-analysis and the use of skilled consultation when we find ourselves in problematic countertransference reactions.

There are significant reasons to cast off the medical model in psychoanalysis. There is, however, a compelling statement made in the Hippocratic oath: Above all, physician do no harm.

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