THE USE OF COUNTERTRANSFERENCE IN THERAPY WITH SCHIZOPHRENIC CLIENTS

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by

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INSTITUTE FOR CLINICAL SOCIAL WORK

We hereby approve the Clinical Research Project

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To Robert L. Dean, M.S.W., who recognized the need and who skillfully involved others in the creation of the Institute for Clinical Social Work, an Institute which has given me a rich professional experience.

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One has only to begin a project like this to realize the importance of others. Without the encouragement, counsel and assistance of friends and colleagues, there would be no dissertation. My faculty committee was exceedingly helpful. There are three people in particular I want to acknowledge. First, a client who over the past eight years has taught me about schizophrenia, growth and health. Second, my friend and collaborator in this endeavor, Elinor Grayer, whose intellectual stimulation, vision and generous spirit made the project come alive and our year of work together a joyful experience. And finally, Charlotte H. Martin, whose knowledge, love and patience gave me the foundation for this dissertation. Thank you.

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ABSTRACT

Countertransference is examined first in its historical context and then as a treatment tool. The evolution of the concept is traced from 1910 to 1979 through a review of the psychoanalytic literature. The literature revealed that, until recently, countertransference was utilized solely to provide information about the therapist. More recent authors recognize that a client's projections influence the therapist. One of these recent authors was Heinrich Racker. He viewed countertransference as deriving in part from the therapist's past, and in part from the therapist's identification with the client. Racker's theory is one of the theoretical bases for this study. The second base is Harold Searles' approach to the treatment of schizophrenia.

An operational definition of countertransference is developed for this project.

The purpose of this study is to explore countertransference as an avenue of information about the client and the client's internal objects. The question addressed is: Can countertransference be used to identify the emotional attitude of the schizophrenic client toward the therapist, as well as detect changes in that attitude? Schizophrenia is defined and described, and Searles' interpersonal psychodynamic treatment approach is elucidated.

The method of investigation is to view countertransference feelings as identifications with the client or his internal objects. This project demonstrates that viewing countertransference experiences in this manner can enlighten the therapist about the client. The therapist is provided with information about the client's self experience,

perception of the therapeutic relationship, and the client's perception of the therapist via the observation of one's counter-transference. This enables the therapist to deal more easily and more effectively with a psychotic transference.

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CHAPTER 1

INTRODUCTION

This study began when I as a therapist found myself experiencing emotional reactions that were distracting and distressing; these were emotions which certainly interfered with a calm, neutral response to my client. It seemed not to matter what the nature of these reactions were, whether anger or love, suffocation or dislike, boredom or outrage. It was the intensity of the emotional experience which created the interference. This study resulted from this author's attempt to understand those reactions and to understand their meaning in terms of the therapeutic relationship. Thus, was my interest in understanding countertransference born.

In order to make this exploration it was necessary to comprehend the concept of countertransference, its definitions and uses, its sources and the various theories regarding it. Thus, an historical study of the concept through the literature is also a part of this project.

The history of the development and evolution of the concept of countertransference as is recorded in the literature is recapitulated in this author's personal experience. A brief overview will clarify that comparison. First, there was an awareness of countertransference feelings, followed by their identification. Second, and almost immediately, followed a feeling of shame. It felt as though this unsavory and uninvited participant in the therapeutic interchange should be excluded, much as one tries to exclude a shameful and "bad" family member from the fold. Following the recognition of shame was

a grudging acknowledgement of the constant presence of countertransference, and finally an admission that therapists are emotionally human and even when analyzed retain vestiges of non-rational, even neurotic perceptions. Finally, a somewhat less judgmental acceptance of the countertransference experience ensued. Gradually, this therapist's emotions were granted membership in the family of psychotherapeutic events. With that acceptance came the ability to explore personal responses in the context of the therapeutic relationship. The concept of countertransference evolved through similar phases, and currently countertransference seems to be the "favorite child" of some theorists who now view it as a valuable therapeutic tool. Indeed, Issacharoff (1979) describes countertransference as the "living response to the patient's emotional situation at a given moment." (p. 30) It still remains for that piece of the therapeutic interaction to achieve full integration. That can occur only when countertransference is neither positively nor negatively valued, but like transference is seen as an integral and inseparable part of the therapeutic process. Chapter three examines how the concept of countertransference paralleling the author's experience evolved through phases in the growth and maturation of the theory of psychoanalytic psychotherapy.

Through the literature review, the work of Heinrich Racker emerges as original, thoughtful, integrative, and remarkable. Racker developed a theoretical model for the examination of countertransference responses. His understanding of the phenomenon was a marked departure from the thinking of the theoreticians who preceded him. Racker's

theory is highlighted and a detailed review of his work is included.

The literature review also revealed that a number of definitions of countertransference exist but that a universally accepted one has yet to emerge. Accordingly, this study develops an operational definition of countertransference. The definition of countertransference that most adequately encompasses this author's experience of the phenomenon is not that of the "classical Freudians" who see countertransference as coming solely from the therapist's history. Rather, it is more closely aligned with those who see countertransference as a result of both what the therapist transfers from personal experience and what the therapist experiences through introjection and identification. The operational definition of countertransference used in this study is described in Chapter Two. Chapter Two contains the statement of the research question, the assumptions and definitions pertinent to this study. Chapter Three is, as indicated above, the history of the concept of countertransference as reflected in the literature. Chapter Four describes Racker's theory of countertransference. The description is detailed and covers his entire theory. A diagram of Racker's conceptualizations which this author developed is used in this chapter to illustrate the model described.

Chapter Five describes schizophrenia, its etiology, the level of developmental arrest, the intrapsychic structure and the clinical manifestations. It focuses on Harold Searles' understanding of schizophrenia. The latter half of the chapter summarizes Searles' treatment philosophy and examines the phases of the treatment process as described by Searles. There is nothing comparable in the literature

to Searles' elaboration of the phases of therapy with a schizophrenic client. His clarification of the process with its fixed benchmarks provides a map and compass to the therapist who otherwise could easily feel quite lost. Rather than feeling that therapist and client are wandering in obscuration, one can see where the client is in the therapeutic process as well as what lies ahead.

Three reasons determined the choice of schizophrenic clients for this study: (1) There is a great need for tools in any psychotherapeutic endeavor with schizophrenia clients due to the problems aroused by the length of treatment and the intensity of the psychotic transference; (2) this population is inadequately served in terms of the variety of psychotherapy available to it, i.e., psychotherapy which has structural change as its goal rather than psychotherapy which has only palliative results as its goal; and (3) clear verbal exchanges of information with schizophrenic clients are the exception rather than the rule (in contrast with clients who are more able to engage in secondary process thinking); therefore one's countertransference may be a substitute conveyor of helpful information which is not available through the usual verbal channels.

Chapter Six explores the research question by applying Racker's countertransference theory to Searles' treatment theory. Only in its application is it possible to discover the real value and/or limitations of an idea. The research questions are postulated to provide a framework in which the therapeutic interaction can be examined from the point of view of making the countertransference experience central. Although therapy is an interactive or transactive, multidimensional and ongoing process, the questions are a means of freezing the action

at a particular point much as one does with a camera. This has both the advantage of being able to examine the moment closely, and the disadvantage of to some extent changing the moment by taking it out of its context. One must acknowledge the difficulties of applying linear thinking (the Research Questions) to a circular process (The Therapy). It is, nonetheless, necessary to ask the question if one wants to understand the therapeutic interaction. Very simply, the question contained within the Research Question is: Given that the therapist experiences countertransference reaction X, does that experience convey any information about the client or the therapeutic process at that moment? Obviously this author thinks it does.

Countertransference can only be investigated if it is clearly described by the person experiencing it. While I know my own counter-transference experience, perhaps it is idiosyncratic; the experience of another clinician can validate or invalidate my own experience. Since Searles courageously described his countertransference thoughts and feelings in his writings, his experiences are used along with mine to furnish the data for this study.

This project studies what happens to the therapist in the course of psychotherapy with a schizophrenic client. It focuses on the therapist's images, feelings and impulses. These are examined for information about the client's attitude toward the therapist, i.e., how the client is experiencing the therapist.

This project is the result of those beginning attempts to broaden my view of countertransference phenomena. It has been written in collaboration with Elinor D. Grayer, M.S.W. Her dissertation is

also a study of the diagnostic use of countertransference and focuses on the use of those reactions with narcissistic individuals. There is an interesting phenomenon which occurs with great frequency; the same discovery is made simultaneously by different researchers working independently of each other. Each of us experienced that coincidence. Each of us investigated countertransference as a diagnostic aid, and each of us found Racker's work seminal.

Our collaboration allowed each of us to broaden our understanding of the use of countertransference as data about the client. The reader is therefore referred to the work of Grayer for a study of the use of countertransference data with narcissistic personality disorders. The two studies taken together cover a wide range of pathological conditions. Chapters Three and Four were collaboratively written and are identical in each work.

This is a heuristic study--one which serves to guide, to discover, to reveal; one which is valuable for empirical research and yet is, in itself, incapable of providing proof. It represents an effort to understand and systematize clinical experience. The basic theory, which led to the questions posed in this study, was built out of that clinical experience, rather than using theory to determine experience. The results, it is hoped, demonstrate the value of the approach.

This project is a theoretical study of the concept of counter-transference and its use as a diagnostic tool. Specifically, this project explores the use of countertransference as a source of data about the changing attitudes of schizophrenic clients towards the therapist.

CHAPTER 2

THE RESEARCH QUESTION

RESEARCH QUESTIONS

This project addresses the question: Can countertransference reactions be used to identify the emotional attitude of the schizophrenic client towards the therapist, as well as detect changes occurring in that attitude? Two sub-questions grew out of the main one: (1) Can countertransference experiences be used to identify whether the schizophrenic client experiences the "realness" of the therapist's existence and (2) Can countertransference experiences be used to identify the extent to which a schizophrenic individual can differentiate self from other?

The purpose of this project in answering these questions is to explore the use of countertransference as data about the schizophrenic client; that is, to investigate countertransference as a source of diagnostic information. The possibility of so using it was hinted at in the early writings about countertransference, yet never fully developed. It is also the purpose of this study to develop a way of understanding countertransference reactions that will enable the therapist to deal more effectively with schizophrenic clients. It is hoped that this study will permit the therapist to understand better the countertransference vicissitudes of working with schizophrenic clients; that is, to have a framework within which to understand the various elements of the transference.

ASSUMPTIONS

Four basic assumptions are intrinsic to this project: (1) Countertransference is to some degree knowable, i.e., it is a conscious

as well as unconscious experience; (2) Countertransference is always present, as is transference; (3) A client's attitude toward the therapist reflects his or her level of intrapersonal development; and (4) Searles' phases of therapy (1965, 1979) correspond to the phases of ego development described by Mahler (1975), this relationship is elaborated in Chapter Five.

DEFINITION AND DESCRIPTION OF TERMS

For this study countertransference is defined as the whole of the therapist's images, feelings and impulses. This includes all of the therapist's responses--conscious and unconscious, feelings and associations, thoughts and fantasies--to the client, the client's material and affects, and to the interaction between them. In part, these responses are determined by the therapist's past relations (especially those with significant others, e.g., family) and in part by the therapist's realistic and neurotic needs. In addition, countertransference is determined by the therapist's identification with the client's personality (id, ego and superego) as well as the client's internal objects. The history and theoretical basis for this definition of countertransference is elaborated in the next two chapters.

"Attitude" is defined as "a readiness of the psyche to act or react in a certain direction." (Hinsie and Campbell, 1970, p. 75). In this project, the term is used to denote the client's readiness to act or react, based on those major developmental arrests or accomplishments which are related to the client's progress through the phases of psychological growth. The term does not refer to the vicissitudes of feelings that shift momentarily during the ebb and

flow of any one therapy hour.

Schizophrenia is described in Chapter Five. Essentially, this study's use of the term conforms to the definition in the Diagnostic and Statistical Manual of Mental Disorders (Third Edition (1980), also summarized in Chapter Five.

"Realness," as used in this study, denotes that which actually exists, that which has an objective existence of its own. In the first sub-question above, the term asks whether the client can experience him or herself as being in the presence of another person who is alive in the present world and not someone from the client's past, a product of his or her fantasy, or a non-human entity.

EXPANSION OF THE QUESTIONS

Searles' treatment approach to schizophrenia views the client as moving (in the transference) through several phases. The initial two phases are referred to as pathologic symbiosis and autism. During these phases, the client either misidentifies the therapist or does not relate emotionally. The client is either not conscious of the therapist's existence or appears to be oblivious to the therapist. Therefore, the first sub-question asks whether countertransference responses can be used to identify whether the client is in the pathologic symbiotic or autistic phase of the transference.

The second sub-question is: Can countertransference experiences be used to identify whether the schizophrenic individual has acquired the ability to differentiate self from other? Lidz, et al (1965) wrote:

> "The deficiency in a sense of autonomy forms a critical aspect of schizophrenia...Indeed, boundaries between the endopsychic and the external, between his feelings and those of others, are diffuse." (p. 366)

The establishment of ego boundaries allows one to differentiate one's own feelings from those of someone else. This ability is essential to the development of a sense of self, a sense of identity. According to Searles, such differentiation can occur only after a period of symbiosis. His theory of treatment approximates the growth and development of the infant as described by Mahler (1975). The growing ability of the individual to separate and individuate (which results in a sense of autonomy) is a product of the resolution of the therapeutic symbiosis. Searles calls this process the phase of individuation, the final phase of therapy.

Using Searles' treatment approach as a framework, the second sub-question asks if countertransference responses can be used to identify whether the schizophrenic client is in the process of resolving the therapeutic symbiosis, whether he or she feels separate from the therapist; that is, has he or she entered the phase of individuation?

Theoretically, one can focus on any point in treatment and examine the countertransference responses at that moment. If the research question can be answered affirmatively, i.e., if counter-transference can identify the emotional attitude of the schizophrenic client towards the therapist as well as detect changes occurring in that attitude, then at any point in the therapy one should be able to identify the client's attitude as well as his or her intra-psychic development level. This project uses clinical material to make that exploration. The clinical material used focuses on the intrapsychic and interpersonal processes that occur during the phases of pathologic symbiosis, autism and individuation.

Chapter Six examines both this author's countertransference responses and Searles' countertransference experience as reported in his writings. Both of these will be examined in relation to Racker's theory concerning the informational value of countertransference. Racker (1968) stated:

> "Countertransference reactions have specific characteristics (specific contents, anxieties, and mechanisms) from which we may draw conclusions about the specific character of the psychological happenings in the patient." (p.129)

Countertransference reactions will be examined to see if they give information to indicate (1) whether the client is in the autistic or pathologic symbiotic phase of transference, and (2) whether the client and therapist are no longer in a therapeutic symbiosis.

CHAPTER 3

THE EVOLUTION OF THE CONCEPT OF COUNTERTRANSFERENCE AS REFLECTED IN THE LITERATURE

INTRODUCTION

Research into the history of countertransference literature has been an intriguing journey into the operational dynamic of the psychoanalytic community as well as an investigation of the material produced.

The thrust of this chapter is intended to go beyond a standard literature review. It is designed to be an evaluative study of the evolution of the concept of countertransference, using the literature as the medium. This portrayal of the concept is intended to facilitate the use of countertransference in the new way which is the major thesis of this dissertation.

The term "countertransference" was coined by Freud in 1910, 71 years ago. The literary output of 69 of those years (1910-1979) was scanned. Four comprehensive indexes were searched, using both "countertransference" and "transference" as key words.[1] In addition, the words "analyst" and "psychoanalytic treatment" were used as search words. The bibliography is comprised of material published as books or in books, and of journal articles. Forty-two journals are represented. In all, 201 references were obtained, representing approximately 160 authors.

The simple statistics concerning this literature are themselves

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1 Chicago Psychoanalytic Index, Psychological Abstracts, Science Citation Index, Index Medicus.

fascinating. For example, the number of articles published in the early years is sparse. The first post-Freud reference was written in 1919 by Sandor Ferenczi. From that year until 1949, only 19 references to countertransference were found.

Of these, the more frequent references to countertransference appear during the late 1940's. Most of the discussions have a defensive cast to them. No substantive treatment of the subject emerges, and it is clear that very few significant contributions were made during those years.

Thus, the first 38 years (1910-1948) following Freud's identification of the concept produced only 19 pieces of literature devoted to it, an average of only one every other year. By contrast, the next thirty years produced 182 references, about six per year--an increase of more than ten times over the first 38 years. Of these 182, the 1950's yielded 59 references, including an issue of one journal devoted entirely to countertransference.[2] The balance of the 123 was published in the past 20 years, again showing increasing interest. Nevertheless, even this output is meager indeed, compared to other important concepts, especially for a discipline so committed to delving, studying and writing. The scanty attention paid countertransference is the more astounding when contrasted to the work done in the area of transference; the clear, universally accepted definition of the latter developed early on, whereas a consensus as to the meaning and implication of countertransference has yet to be developed.

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2 International Journal of Group Psychotherapy; October 1953, Vol 3, No 4.

What happened? Why was so little attention paid to the concept of countertransference when so much was paid to that of transference? Why did there develop a clear, definitive, universally accepted definition of transference while such a definition of countertransference has yet to emerge? And why was so little literature produced for almost 40 years, and then (comparatively) so much?

It seems clear that something inhibited that investigation, something produced intense resistance to the study of the concept of countertransference. Perhaps the answer lies in the nature of the concept itself and in the social tenor of the times.

Transference is relatively easy to consider. Basically, it grows out of the client's internal perceptions. It is experienced by the client and observed by the therapist. It is clear to whom transference belongs. Its investigation allows the therapist to remain the impartial, objective and removed observer.

Countertransference is the polar opposite. It is also clear to whom countertransference belongs. It grows out of the therapist's internal perceptions. It is experienced by the therapist. Its investigation undermines the assumption that the therapist can be impartial, objective and removed. It seemingly puts the lie to the view of psychoanalysis as a science and of its practitioners as objective observers and blank screens. Countertransference both involves and belongs to the therapist. In Freudian terms, it tells of the therapist's conflicts and unconscious wishes--in short, of the therapist's vulnerabilities. It certainly interferes with ideal of a "blank screen" therapist perfectly in control of his impulses, perfectly aware of his conflicts.

It has been suggested that part of the resistance may have

developed out of the "scientific cast" of psychoanalysis, from the effort to see it as an analytic science, and to see the therapist as an objective observer hindered only by personal pathology, much as he or she would be hindered in any endeavor. Small wonder then, that the exploration of countertransference met with such resistance. Who would undertake to explore--expose to public view--one's vulnerabilities, conflicts, urges, even pathologies? The recognition of countertransference feelings aroused shameful feelings. How much more so could be evoked by its revelation.

In addition, much of the earliest writing points to counter-transference as an expression of either the therapist's unresolved narcissistic needs or as an expression of the male therapist's libidinal urges towards the female client--sometimes both. Every emotional reaction on the therapist's part was seen as a violation of the rule of abstinence, a chink in the professional wall. How difficult it must have seemed in that climate to explore the therapist's emotional response. It was difficult to accept the possibility of a therapist responding irrationally to a client, even when provoked by the onslaught of the client's transferences. It had yet to be established that such an onslaught could provoke unconscious conflicts in the therapist which could and should be dealt with.

The earliest writers on countertransference attempted to demonstrate the existence of the phenomenon. They discussed the likelihood of its inevitability. However, it was understood as something to be eliminated, not as something to be used.

The earliest (1910) mention of the countertransference is in a Freud paper entitled, "The Further Prospects of Psychoanalysis." In that address, Freud said, in part, "we have become aware of the countertransference which arises in (the physician) as a result of the patient's influence on his unconscious feelings"..."and have nearly come to the point of requiring the physician to recognize and overcome the countertransference in himself." (p. 144-145). That is, Freud viewed countertransference as the physician's (therapist's) unconscious response to the patient's transference reactions, with the implication that it represents a pathological response on the therapist's part. He thus saw this countertransference as a hindrance to the work of the psychoanalysis and formulated the requirement that the therapist begin professional activity with a personal analysis and continually carry it deeper while observing clients. However, two years later, Freud (1912) wrote, in another address, that the therapist "must turn to his own unconscious like a receptive organ towards the transmitting unconscious of the patient...so that the doctor's unconscious is able to reconstruct the patient's unconscious." (p. 115-116). Freud advised that the therapist may not tolerate those resistances which hold back from one's consciousness what has been perceived by one's unconscious. That is, Freud counseled that the therapist use his[3] unconscious to gain an understanding of the client's unconscious. Here, then, is a hint that the therapist's responses to the client are a part of the therapeutic interaction and

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3 Freud apparently did not anticipate the possibility of a significant number of female therapists.

may not be inherently pathological. To the contrary, they may aid and enhance the therapeutic process. These two conflicting views of countertransference--as hindrance and as aid to treatment--have persisted for almost 70 years.

Freud's writings about countertransference reflect his discomfort with the phenomenon. For example, in a letter to Ludwig Binswanger (1913) Freud wrote:

> It is one of the most difficult ones (problems?) technically in psychoanalysis. I regard it as more easily solvable on the theoretical level. What is given to the patient should indeed never be a spontaneous affect, but always consciously allotted, and then more or less of it as the need may arise. Occasionally, a great deal, but never from one's unconscious. This I should regard as the formula. In other words, one must always recognize one's countertransference and rise above it, only then is one free oneself. To give someone too little because one loves him too much is being unjust to the patient and a technical error. All this is not easy, and perhaps possible only if one is older. (p. 50)

Freud implied that one's love for the patient can produce unfortunate results, but that controlling one's feelings is difficult--especially in one's younger years. Not only did Freud imply sexual love, he also raised a thought not again addressed until Winnicott did so in 1949, i.e., that the therapist will have feelings for the patient--love, and by implication hate, the affects of every relationship. Freud (1915) warned of the dangers created by the mixture of personal investment in professional relations.

> To the physician it (the phenomenon of the patient falling in love with each successive analyst) represents an invaluable explanation and a useful warning against any tendency to countertransference which may be lurking in his own mind. He must recognize that the patient's falling in love is induced by the analytic situation and is not to be ascribed

> to the charms of his person, that he has no reason whatever therefore to be proud of such a 'conquest' as it would be called outside analysis. (p. 379)

And again,

> ...and besides, this experimental adoption of tender feeling for the patient is by no means without danger. One cannot keep such complete control ofoneself as not one day suddenly to go further than was intended. In my opinion, therefore, it is not permissible to disavow the indifference one has developed by keeping the counter-transference in check. (p. 383)

The struggle between viewing countertransference either as a hindrance or as an aid seems to reflect the struggle between accepting the therapist as humanly fallible, or as a scientific creature, psychoanalytically purified, capable of rising above one's responses, and therefore of objective observation.

The earliest writers, following Freud, struggled both to define countertransference and to identify its source. In the first post-Freud reference found, Ferenczi (1919) viewed the countertransference as a manifestation of the therapist's pathology. Ferenczi identified the source of the countertransference as the therapist's unconscious sexual impulses. It is revealing that he, along with Freud and the majority of the writers in those years, struggled with what they characterized as their unconscious sexual impulses, apparently assuming that these impulses could easily fall prey to the onslaughts of their client's transferences. Small wonder that the countertransference was understood only as pathology, and mandated to be analyzed away.

Ferenczi thus viewed the countertransference as a manifestation

of the analyst's pathology,[4] at least in part. He cautioned that the therapist must learn to control his affects, not repressively, but through deeper self-analysis. Ferenczi believed that if the therapist could acquire such control, what he termed "mastery of the countertransference", then the therapist could let go during the treatment situation, according to the treatment requirements. Ferenczi discussed, and to some extent clarified, the difference between resistance to the countertransference and control of it. This notion--resistance to countertransference--re-emerges many years later, especially in the works of Glover (1927-28), Little (1951), Racker (1968), Spotnitz (1969) and Margolis (1978).

Ferenczi's attention to countertransference remains more intense than that of most writers; perhaps because he worked more with profoundly disturbed clients--those whom we would today label psychotic. He took these clients into his home, so that his involvement with them became more complicated than did the more standard analytic relationship. Clara Thompson (1943), writing many years later, discussed Ferenczi's thoughts regarding countertransference:

> Two of his ideas I have found of great value; i.e., that involving the interaction of two personalities, and that no therapeutic results are possible unless the patient feels and is accepted by the analyst. He believed that the patient is ill because he has not been loved, and that he needs from the analyst the positive experience of acceptance; i.e., love. This could not be given by a mirror. (p. 64) ...He therefore came to the conviction that the real personality of the analyst plays a part in the therapeutic process, that his blind spots, shortcomings and also positive qualities are felt

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4 Ferenczi shared Freud's practice of referring to the therapist in the male gender. Throughout this chapter, the practice of the original author is preserved in quotes and paraphrases.

> intuitively by the patient who reacts to them. In consequence, any consideration of the patient's attitudes should include an evaluation of the reality relationship to the analyst. (p. 64)

Thompson (1943) notes that Ferenczi believed the therapist should admit to the patient when the therapist is wrong. However, Ferenczi cautioned that "the aim of the statement is to correct a misconception and is made in the interest of clarifying the situation, not to help the therapist, nor an invitation to mutual analysis." (p.65)

Ferenczi also discussed the client's influence on the therapist's unconsciously derived responses. He described the therapist's subjective experiences and the therapist's inner responses to hearing the client's free associations. Ferenczi saw the psychoanalytic process as one in which the therapist moves between empathy, self-observation and evaluative thinking. That is, the therapist acceptingly receives the client's free associations. Ferenczi said that we must permit our own associations and fantasies to respond, explore any connections that may develop and finally, we must evaluate critically and carefully our subjective trends.

As indicated, Ferenczi also believed that there is an interaction between client and therapist, and that the countertransference grows from that relationship. Consequently, with regard to the client's inappropriate expectations of the therapist, Ferenczi wrote:

> ...the patients are simply unmasking the doctor's unconscious. The doctor can swear that he - consciously - intended nothing but the patient's cure; but the patient is right also, for the doctor has unconsciously made himself his patient's patron or knight and allowed this to be remarked by various indications. (p. 188)

Some years later in an article entitled, "The Therapeutic Technique of Sandor Ferenczi," Izette DeForest (1942) argues (via

Ferenczi's thinking) for the controlled use of the countertransference:

> To use the countertransference as a technical tool, as one uses the transference, dreams, association of ideas, and the behavior of the patient seems to many analysts exceedingly dangerous. Much of this fear has to do with the analyst's fear of his own impulses, his intuitional weakness and his lack of self-knowledge...but, in addition to this, there often is among analysts a preference for the teacher-pupil relation, a didactic and distant attitude toward the patient, rather than the tender parental attitude...the basis of this kind of treatment seems to be anxiety, as evidenced in the analyst's insecurity in himself and in the patient's awe of the analyst. (p. 136)

A dominant theme throughout the early years is the distrust of the development of any feelings on the therapist's part towards the client. The predominant thinking said these feelings could only be a hindrance. Not so, said Ferenczi. His stance put him at odds with the thinking of his time, perhaps way ahead of his time. He recognized the necessity of the therapist's real acceptance of the client; he saw the importance of the interactional process and he accepted the idea that the therapist and client unconsciously influenced each other.

Despite Ferenczi's view, countertransference was to continue for some years to be the black sheep of the psychoanalytic family. In 1924, Adolph Stern delivered a paper to the American Psychoanalytic Association. This address appears to be the first mention of countertransference made to an American audience, or published in an American journal, and may have been the first paper ever to deal extensively with the subject of countertransference. Stern defined countertransference as the therapist's transference reactions to the client and therefore, defined them as a reliving of the therapist's past in terms of his present. In Stern's view, the major source of

countertransference derives from the therapist's narcissism. He joined other writers and discussants in his view of countertransference as only a problem, and in his recommendation of analysis for the therapist as the only solution to that problem. Stern believed that the transference was the sole source of countertransference.

Stern's thinking and writing are essentially restatements of Freud's earlier writings. He reiterated Freud's comments that the client's love for the therapist evokes repressed infantile material within the therapist. This material, deriving from the therapist's narcissism, is the major source of countertransference. Stern hinted that countertransference may arise independently of transference, but did not explain how. He did say that a certain amount of countertransference normally exists in the treatment situation, but again did not specify normality, nor under what conditions "normal" could prevail.

It seems that the attempts to deny countertransference manifestations did not sit comfortably with Stern and the other early investigators. It also seems that they did not feel at ease allowing themselves to accept its existence. What a dilemma! One can speculate that a parallel exists between the therapist's difficulty with countertransference responses and the client's difficulty with libidinal urges for the therapist, and the former is probably fraught with just as much shame as the latter.

While Stern's discussion basically follows Freud's conceptualization, he went on to explore some aspects more fully. Stern described two spheres of countertransference: the positive, represented by the therapist's response to the female client's love for

the male therapist, and the negative, which he saw as essentially anxiety in response to intense resistance.[5] He proposed a solution for each of these spheres. In the first situation, Stern (restating Freud) believed it important to recognize that the therapist is an image for the client, and that the client's love is not real but a transference manifestation. Therefore, Stern believed that the therapist's task was to disengage from the transference: i.e., not to become flattered by the client's adoration but to recognize the flattery as derived from the client's fantasy life.

The second sphere of countertransference involves the therapist's anxiety in the face of the client's intense resistance. Stern viewed this anxiety as deriving from the therapist's aggressive energies. He felt that the "fault" lay in the therapist's reacting to the client's unconsciously determined activity as if it were consciously determined and occurring in the present--that is, misunderstanding the client's transference manifestations. The thrust of his thesis perpetuates the belief that the therapist can and should function as a perfectly "scientific creature," capable of objective and scientific observation under the right conditions. Stern implicitly recognized the emotional dimension of the therapist, cast it in a pejorative light and advised that with sufficient analysis that human frailty can and will be eliminated. In his view, as in the majority of the discussions of that era, there seems to be a belief in the ability of the therapist to achieve a state of

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5 In common with many other writers, Stern's language reflects no awareness of the existence of female therapists. He addressed only the issue of male therapists and female clients. We do not know whether he indeed had so narrow a view or whether he did not believe that a woman therapist would experience this countertransference problem vis a vis her male clients.

what might be called professional perfection. In other words, he hypothesized a state wherein no instinctual feelings are allowed, a state in which the urge is as shameful as though acted upon, the thought as evil as the deed. A sense of embarrassment seems to have prevailed overall. No one knew what to do with the therapist's feelings. The existence of the problem belied the scientific protestations of psychoanalysis, yet the authors could not ignore so obvious a reality.

Thus, the majority of writers understood countertransference as a hindrance to treatment. Nevertheless, there is a small number of earlier writers who understood it as more. Some of these even presaged the current writers, using definitions and terms that only have recently re-emerged into use. Except for Ferenczi, most of these early pioneers were women. Until Winnicott's writings in 1949, women were the main dissenters from the established view of countertransference as a hindrance to treatment and as evidence of the therapist's pathology.

As a result, in contrast to other psychoanalytic theory building, much of the contributions about countertransference came from women therapists (Deutsch, Hann-Kende, Reich, Sharpe, etc.). Perhaps during this period, women had easier access than men to their own non-rational processes, and had less need to suppress and deny those thoughts and feelings in the service of competitiveness. And, perhaps women are more sensitive to context and thus able to utilize information incidental to a task, as some of the latest brain research indicates (Duren-Smith, 1980). These contributions, however, had little effect on mainstream thinking.

One of these dissenters was Helen Deutsch. In 1926, she took exception to the view of countertransference as solely a hindrance. She published a rather thoughtful article entitled, "Occult Processes Occurring During Psychoanalysis," which was translated and re-published in George Deveraux' book, Psychoanalysis and the Occult (1926). Her thesis is that the intense psychic contact between client and therapist is so very intimate that these transferences can be accounted for by a certain unconscious readiness of the therapist to receive these thoughts. She believed that there are parallel urges in client and therapist; that the client's urges derive from the transference, while the therapist's come from an identification with the client. According to Deutsch, the therapist's ability to form this identification with the client is one aspect of the therapist's unconscious and is part of the countertransference. She named this aspect "complementary attitude" (p. 137). This attitude, she thought, stems from the fact that the client tends to direct ungratified infantile wishes towards the therapist. The therapist then becomes indentified with the original object of these wishes and has urges to respond as might have the original object. The concept is similar to the ideas of Henrich Racker, 27 years later. Historically, it is the first hint that countertransference can be anything other than harmful, or shameful. Deutsch's rather startling message was that countertransference, which had heretofore been viewed as a defect, is now being viewed as useful--even necessary, as a manifestation of identification--a variety of empathic merger. Little wonder that it fell on

deaf ears. There was no response to Deutsch for a good number of years--until 1933 when Hann-Kende took exception to Deutsch's formulation.

Another author investigating countertransference was Edward Glover. In his "Lectures on Technique in Psychoanalysis" (1927 and 1928), he wrote extensively on the concept. He distinguished between different kinds of countertransference, negative and positive. He distinguished between what he called counterresistance and countertransference, although both are defined as reactions to the client's transference manifestations; i.e., the therapist's transference responses to the client's transferences. Glover devoted much of his lectures to identifying techniques for recognizing countertransference and counterresistance, although his definition of each is not very well elucidated. Rather than reaching an abstract definition, Glover described counterresistance anecdotally. He seems to be saying that its development is provoked by countertransference and parallels the client's resistance. He suggested that counterresistance is the result of conscious suppression and unconscious repression of the antagonism aroused by countertransference. Glover (1928, quoted in Bailliere, 1955) stated:

> What the analyst really needs is to have a systematic knowledge of the various types of counterresistance and to be able to recognize rapidly the particular form from which he is suffering at any given moment. As a convenient generalization, we may say that allowing for differences in character, temperament and symptom-type between the analyst and his patient the counterresistances of the analyst in any given situation are similar and equal in intensity to the resistance of the patient in that situation. ...Repression, for example,

> may deal with the analyst's affect and so smother his need for a tu quoque. Nothing is easier for the conscious ego of the analyst than to suppress and for his unconscious ego to repress the antagonism aroused by the patient's defenses. (p.92)

After much detail, Glover hinted at the possibility of using the therapist's counterresistance to assess the level of the therapist's professional development. Further, in his discussion of technique, Glover (in Bailliere 1955) suggested using countertransference feelings, or difficulties in the same way to assess the therapist's conflicts:

> ...the commonest source of counterresistance is to be found in faulty sublimation of the combined impulses of anal-sadism, genital sadism and sadistic curiousity...when in doubt about your patient's difficulties, think of your own repressed sadism. (p. 97)

Or,

> ...a third indication (of counterresistance) is that we cannot explain to ourselves satisfactorily why a patient is still in difficulty. (p.99)

Glover's concept of counterresistance, viz., of a resistance developing out of countertransference, will be recognized in Heinrich Racker's work a quarter century later. Glover did not pursue his concept beyond the point of using counterresistance to diagnose the therapist. In a sense, Glover's ideas do not seem to have caught on, possibly because they so openly and freely accept the frailty and fallibility of the therapist. He said (Bailliere, 1955):

> Anything which stirs up the analyst's id, which in any case is just as active as anyone else's id, is going to cause some internal perturbation... Behind his mask of professional calm and detachment, the analyst's mental apparatus is going to defend itself just as it has always done. (p.90)

Both Glover's concept of counterresistance and Deutsch's concept of complementary attitude remained dormant for at least 25 years.

Jung's only contribution to this subject (1929) appears to be his comment (p. 72) that the analyst "is equally a part of the psychic process of treatment and, therefore equally exposed to the transforming influences."

In 1933 (a & b), Fanny Hann-Kende took exception with Deutsch's formulation. Her view of Deutsch's complementary attitude is restricted to that of the therapist unconsciously identifying with the client's conscious libidinal images. In her view, these identifications are based upon the therapist's transferences, and interfere with the therapy. She considered most of the therapist's identification with the client to be based upon countertransference problems, i.e., the therapist's problems, and she prescribed analysis for the therapist. She did see countertransference as an unavoidable reflection of the therapist's unresolved transferences. She did feel that if the therapist's countertransference could be brought into a suitable equilibrium with the client's transference, then countertransference could actually facilitate therapeutic work. In a vague and poorly defined way, Hann-Kende was one of the first writers to allude to the possible constructive use of countertransference in treatment.

Nevertheless, Hann-Kende seemed to share the generally prevalent discomfort with countertransference. It is as if she felt uncomfortable dealing with it as symptomatic of the therapist's pathology, yet could

not extricate herself from that mind-set. The field was, after all, still new.

Freud was still alive, his disciples still first generation. There was so much opposition from the outside medical community that any internal dissension--even creative thinking--was perceived as a disloyal challenge. Therefore, many of these authors and thinkers tried to explore the concept within the established framework. Their attempts failed. The framework was too small. Nonetheless, the efforts continued.

English and Pearson (1937) dealt with countertransference in three sentences, which seemed to have gone unnoticed. They saw countertransference as everything the therapist feels toward a client. "...the transference process is one that works both ways. It is impossible for the physician not to have some attitude toward the patient, and this is called countertransference." (p. 303) They counselled--not self-analysis--but concealment of "any feelings he may have beyond desire to help the patient." (p. 303) This view was much later to be described as "totalist."

Ella Freeman Sharpe's (1930) article on the "Technique of Psychoanalysis" discusses the phenomenon with little new insight. However, there is one aspect worthy of speculation in her discussion. She comments on the therapist's need to resolve fantasies of omnipotence, since patients inappropriately project such attributes onto the therapist. The implications are that the relationship is a dyad, and that the therapist responds to projections coming from the client, not just to intrapsychic conflicts evoked by the client's

transference. There was no discussion of these implications, which seem to have been made casually, without awareness of their import.

Karen Horney (1939) discussed countertransference as an issue, approaching the phenomenon thoughtfully, creatively and as usual for her, from an interactive point of view. She discussed the potential usefulness of countertransference reactions:

> It would be better for the analyst to admit to himself that he has such reactions (emotional) and to utilize them in two ways: by asking himself whether the reactions he feels are not exactly those the patient wants to effect, thus obtaining some clue as to the processes going on; and as a challenge to a better understanding of himself. (p.66)

Here, Horney directly suggested the use of countertransference reactions as a diagnostic aid. Alas, she was little attended, as if out of synchronization and incongruent with her time. She took exception to the view of countertransference as the therapist's transference, finding the underlying concept too limiting. She speculated that a particular countertransference reaction might be related to the therapist's character. Horney seemed to understand countertransference as deriving from the therapist's narcissistic reactions to the client's "actual behavior." (p.166) She also took exception to the central importance ascribed to unresolved infantile conflicts by classical analysts. This criticism could not have endeared her to her colleagues. Her more democratic view of the interactive elements of the therapeutic dyad must have sat uncomfortably with her more patrician colleagues.

Horney's view of the transference places more personal responsibility onto the therapist:

> There is, however, this to be added: The more we disregard the repetition aspect of transference, the more stringent must be the analyst's own analysis. For it requires incomparably more inner freedom to see and understand the patient's actual problems in all their ramifications than to relate these problems to infantile behavior. (p. 166-167)

The time had not yet come to democratize the therapist-client relationship. The time had come, however, to challenge the faith placed in the ideal of the "sterile" method of therapists, i.e., the belief in the validity of the therapist as mirror. In 1939, the Balints wrote an article which alludes to the likelihood that countertransference grows out of the therapeutic interaction. It pointed out that the therapist creates an impression on the client by the way the office is furnished, e.g., the hardness or softness of the couch. In a myriad of subtle and not-so-subtle ways the therapist colors the client's perception.

> The analytic situation is the result of an interplay between the patient's transference and the analyst's countertransference, complicated by the reactions released in each by the other's transference onto him. (p. 228)

The Balint's view of the countertransference seems twofold: on the one hand they viewed countertransference as the inevitable outgrowth of the transference. As such, the implication is that it is neurotically based. They did reaffirm the need for self-analysis. On the other hand, they implied that "countertransference" can involve the therapist's normal personality; his or her taste in furnishings, comfort, affectual qualities, voice tones, etc., and that these normal qualities all influence the interaction. So,

they did take exception with the norm of the therapist as a blank screen.

The next decade, the forties, was a "latent" period in countertransference thinking. A few works appeared, a few authors made some meaningful explorations, but the material was not substantially different from what preceded it.

Robert Fleiss (1942) explored the phenomenon in the course of his exploration of transference. His paper entitled "The Metapsychology of the Analyst," describes countertransference as deriving both from the transference, and from the therapist's empathy with the client. Fleiss termed this empathy "trial identification." (p. 212-213)

He said that each and every one of the client's neurotic conflicts must be translated into a transference conflict and that the client's transference conflicts, passing through the therapist's "metabolism" must temporarily become the therapist's intrapsychic problems. Thus the therapist's reaction to the transference conflicts (countertransference) is inevitable. The recommended solution is the development of a "work-ego" (p. 221) which Fleiss explained in structural terms.

Otto Fenichel (1941) understood countertransference to be dangerous. His views were slightly at variance with those of his predecessors in that he saw the therapist's libidinal strivings as being less dangerous than the narcissistic needs, consequent defenses and resultant anxiety. He believed that the fear of the countertransference could lead the therapist to suppress all human freedom

and become exclusively a mirror. Fenichel believed this to be a dangerous posture. He warned that the client needs to be able to rely upon the therapist's human qualities.

This ambivalence, i.e., not knowing how to view the therapist's human qualities, was prevalent throughout this decade.

Theodore Reik's book, "Listening with the Third Ear," (1948) was a marvelous breakthrough in the field although an indirect one. Reik wrote about countertransference without so identifying it. This highly personal, almost intimate view of Reik's thinking provides the first and least defensive exploration into the therapist's experiences, roles and attitudes. Although Reik's work is probably the first intimate view of the therapist's reaction (i.e., countertransference), little response appeared in the literature on countertransference in the next years following. Douglas Orr's historical survey (1954) of transference and countertransference makes no mention of Reik's work, nor does Robert Langs' (1976) two-volume publication on the therapeutic interaction. George Frank's (1953) review of countertransference literature refers to Reik's work very briefly, although very favorably.

The chapter entitled "Hide and Seek" illustrates the use of self and self-reactions to increase his understanding of his patient. He related an anecdote told to him by a patient:

> During a performance of Parsifal...in the middle of the most solemn scene he had the most irresistible impulse to shout at the top of his voice: 'matzoknoedel!' (matso balls). The impulse became so intense that he almost succumbed, and only quick flight saved him from the unpleasant scene that would have resulted. (p. 330)

Reik first analyzed the impulse in what he called "psychoanalese." That is, he interpreted the impulse in classical fashion. He then contrasted the "theoretically correct picture" created with the one presented "by the inner observation of my response to the patient's tale."

> While he was describing the scene, his voice had a plaintive or complaining tone. Why did I want to laugh? Here was something serious indeed. Had he yielded to the impulse, my patient would be in jail for disorderly conduct instead of on the analytic couch today. What was there to laugh about? Yet, the temptation to laugh got stronger the longer I followed his story--it became nearly as irresistible as his impulse had been. (p. 331-332)

Reik described the growth of his understanding of that impulse. By means of such analysis, Reik was led back to a clearer understanding of the man's impulse and by way of his own associations, was able to understand the roots of that impulse:

> It is interesting that these fleeting associations in my response contained not only the transitions to the solution but the solution itself...Which of the two procedures is psychologically more useful and appropriate, the objective one or the subjective one? Which leads to the core of the little problem, the road over a textbook or the path over one's own response? (p. 334)

Reik underscored his point that objectivity is often irrelevant. "Lack of understanding is regrettable, but misunderstanding in the form of misconstruction is deplorable." (p. 335) Reik postulated that the surest road to understanding is the one through the therapist's own emotional and often non-rational responses:

> We have, I believe, seen that it is not the other persons impulse as such, but <u>its unconscious echo in the ego</u> that is the determining factor in psychological conjecture. Thus our own mental reaction is a signpost pointing to the unconscious motives and secret purposes of the other person. (p. 468)

Reik's statement is an echo of Freud's (1912) statement that "...(the therapist) must turn to his own unconscious like a receptive organ towards the transmitting unconscious of the patient... so that the doctor's unconscious is able to reconstruct the patient's unconscious." (p.115) As did Freud's, it presupposes profound self-knowledge and self-analysis. Reik's confidence and vigor in exploring his response and reactions, his ability to separate himself from his clients, was born of thorough self-analysis. The book was a significant landmark in the history of the literature on counter-transference. According to Joseph M. Natterson (1966), one of Reik's biographers, "The increased interest of analysts in the therapeutic importance of countertransference phenomena probably stems in part from Reik's contributions." (p.260) Reik was a dissenter from the established "scientific" approach to psychoanalysis. He was also somewhat outside the accepted circle of psychoanalysts in the United States, inasmuch as he was not a physician. Possibly, his freedom to question the status quo derived from his lack of attachment to it.

During these years, some authors began to consider the nature and composition of the phenomenon. In other words, how can one define, delimit and describe countertransference.

Ella Freeman Sharpe (1947) used the term somewhat broadly to include the therapist's conscious and unconscious reactions to the client.

> 'Countertransference' is often spoken of as if it implied a love-attitude. The countertransference that is likely to cause trouble is the unconscious one on the analyst's side, whether it be an infantile negative or positive one or both in alternation.

> The unconscious transference is the infantile one and when unconscious will blind the analyst to the various aspects of the patient's transference...We deceive ourselves if we think we have no countertransference. It is its nature that matters. We can hardly hope to carry on an analysis unless our own countertransference is healthy, and that healthiness depends upon the nature of satisfaction we obtain from the work, the deep unconscious satisfactions that lie behind the reality ones of earning a living and the hope of effecting cures. (p. 4)

Writing in 1949, Leo Berman defined countertransference through the transference relationship, i.e., as the therapist's reaction to the client as if the client were a significant figure in the therapist's past life. He then distinguished countertransference from "real reactions," i.e., those emotional reactions which the therapist experiences as a person during the session. These reactions include appropriate emotional responses and defenses. Berman stated that qualitatively, the therapist's responses to the real relationship will be the same as most people's. However, the quantitative aspects should differ. According to Berman, the therapist's process of analyzing and controlling countertransference feelings can be an important therapeutic experience for the client. Reik, focusing upon the therapist's experience, wrote of the therapist's feelings as a road to the client's unconscious. Berman, on the other hand, wrote of the therapist's process as a model for the client's development, de-emphasizing the therapist's experience, and focusing on the impact of the therapist upon the client. By 1949, the views of countertransference were shifting.

To recapitulate, until 1949 countertransference was largely

understood as a source of trouble. Some authors (such as Ferenczi) advocated open expression of feelings towards the client, so as to make the therapist seem more human. The majority advocated a neutral attitude or "blank screen" as the only proper therapeutic stance and consequently, understood countertransference as an unwelcome intrusion of the therapist's unconscious into the therapeutic situation. A few authors explored the positive, even useful aspects of countertransference reactions although in rather tentative fashion. The climate continued as one of suspicion and ambivalence. The therapist was still idealized and believed capable of true scientific objectivity.

However, the next few years produced literature which diverged markedly from previously held theories. Forty years after Freud, 26 years after Deutsch first hinted at it, 23 years after Glover tentatively explored non-pathological aspects of countertransference, the topic of the therapist's emotional responses in the therapeutic dyad began to move out of the closet of intrapsychic conflict and into the arena of being seen as a function of the relationship between client and therapist. A more comprehensive investigation of the concept began to appear in the literature. What has come to be called the totalistic[6] view began to emerge.

A significant and professionally accepted break in the traditional view occurred in 1949 when D.W. Winnicott wrote his article "Hate in the Countertransference." He distinguished three components (or sources) of countertransference:

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6 The term used by those who define countertransference as all of the therapist's feelings towards the patient. See Frank, Kenneth (1977).

> 1) abnormal countertransference feelings in the therapist that are based upon set relationships and identifications that are repressed by the therapist,
>
> 2) identification and tendencies, belonging to the therapist's personal experience and development, which provide the positive setting for the therapeutic work, and
>
> 3) objective countertransference - the therapist's love and hate in reaction to the actual personality and behavior of the patient, based on objective observation. (p.69-70)

Winnicott basically referred to work with psychotic clients. However, his discussion describes some ways in which the therapist can manage his or her hatred towards the neurotic client. The article concludes with a discussion of the many reasons for a mother to hate her child, and ways for her to handle and control this hatred. It draws a likeness between the mother's hate and the therapist's and in so doing draws negative countertransference feelings into the realm of normal. Winnicott considered only his first dimension of countertransference as pathological. He used the term countertransference to refer to all feelings and reactions within the therapist towards the client. In a sense, Winnicott became the first totalist -- the term applied to those who define countertransference as all the feelings the therapist has for the client, not just those deriving from the therapist's unresolved conflicts.

Winnicott also devoted considerable attention to a discussion of the <u>function</u> of the countertransference:

> ...in certain stages of certain analyses, the analyst's hate is actually sought by the patient, and what is then needed is hate that is objective. If the patient seeks objective or justified hate he must be able to reach it, else he cannot feel he can reach objective love. (p.72)

And also:

> It seems to me doubtful whether a human child as he develops is capable of tolerating the full extent of his own hate in a sentimental environment. He needs hate to hate. If this is true, a psychotic patient in analysis cannot be expected to tolerate his hate of the analyst unless the analyst can hate him. (p.74)

Winnicott's discussion of the therapist's hate seems to have profound implications. Implicit in his rigorous discussion is the concept that the therapist's feelings towards clients are not only normal and proper, but useful; useful as a modeling experience and useful as an opportunity for the client to work through complementary feelings aroused by the therapist's countertransference. The function of the countertransference has been alluded to by other authors (Deutsch, 1926; Fleiss, 1942; etc.). However, Winnicott's writings were not ignored; in fact they were rather well received. They were also the springboard for a wealth of literature on countertransference which appeared in the next decade, the fifties.

It is difficult to know why Winnicott's article struck so responsive a chord. Perhaps his analogy to the mother's normal hate for her child removed some of the stigma usually attached to countertransference feelings. Perhaps Winnicott's discussion of both how to deal with hateful feelings towards one's client, and the usefulness of such hateful feelings implied an acceptance that allowed for new ways of thinking. Or perhaps the time was right for Winnicott's article, and the field was ready for just such a discussion and exploration. Whatever the cause, the publication of Winnicott's article marks a turning point

in the history of the concept. After Winnicott, the volume of literature produced increases markedly. The tenor of the discussions seem more rigorous and more exploratory. There seems to be less need to see the therapist in a clinically sterile, scientifically objective cast. The therapist as an emotional creature seems to be born and accepted into the analytic world. The therapist within the therapeutic dyad, emerges as a focus of interest and investigation.

The new writings are much more vigorous, much more exploratory of the concept than the earlier ones. To be sure, some authors re-espoused the traditional classic view. However, many more authors explored the function of countertransference, explored its sources, began to think of the phenomenon as a normal concomitant of the therapeutic interaction. Thus, the articles written during the decade of the 1950's breathed life into the examination of countertransference. As we shall see in the discussion of the literature of the decade, the contributions of Winnicott (1949), Heimann (1950), Little (1951, 1957), and Racker (1953) are seminal. These authors turned to the data of countertransference to furnish a fuller understanding of the client in the process of psychotherapy. That is, they made diagnostic use of the data provided by the countertransference. It was these authors whose writings broke through the then prevailing classical view of countertransference as an obstacle in the psychotherapeutic path. Indeed, according to Feiner and Epstein (1979):

> Their (Racker, Little, Hiemann, Winnicott) ideas concerning the therapeutic usefulness of countertransference data have foreshadowed all subsequent developments, and their papers are even today the most widely quoted in the literature. Racker's elaboration of countertransference

> theory, and of the use to which counter-transference data may be put in clinical practice, remains probably the most comprehensive and original contribution by any single author. (p.1)

What happened in those years to open the door to exploration of the therapist's countertransference? Were there changes in societal values? Had the profession matured in some way to permit an accepting examination of what heretofore had been viewed with shame and quick repression? When the profession was young, the internal pressures for perfection were intense. (The situation parallels that a child who experiences internal pressures to "be good"; with maturity comes an increased sense of self, self-worth, and the capacity for evaluative introspection--so with the profession.) With the experiences of external acceptance came the ability to be less than perfect, to be scientifically fallible. Along with this developed the confidence to accept that one may not be so very different from one's clients.

Witenburg's article (1979) entitled, "The Inner Experience of the Psychoanalyst" explores the factors which spurred the growing study of countertransference phenomena beginning in the fifties. He credits the growing maturity of psychoanalysis coupled with social pressures:

> Couple the social pressure with the growing maturity of psychoanalysis and you have pressure on the profession to be more open. The widespread acceptance in our field of of the fact that each of us is potentially the other makes us aware of how similar we can be to our patients. We are all more accepting of human frailties than we used to be. (p.45)

It was the right time for intensive exploration, for theory-building and for studying the therapist as subject matter. The literature burgeoned.

In 1950, Paula Heimann wrote a paper entitled, "On Countertransference" which in a broad yet thorough fashion reacts to the view of countertransference as nothing but trouble. Her ambitious article covers many aspects of the phenomenon. She defined countertransference. She explored its use as a means to understand the client; she then considered the possibility that the therapist's countertransference is created by the client. She suggested that the term "counter" goes beyond the transference reactions of the therapist to become a counterpart of the client's feelings. She returned to the substance of Freud's comment (1912) in that she saw the therapist's emotional responses as an important tool of research into the client's unconscious. Her definition of countertransference can also be described as "totalist." Heimann (1950) wrote:

> For the purpose of this paper I am using the term 'countertransference' to cover all the feelings which the analyst experiences toward his patient. It may be argued that the use of the term is not correct, and that countertransference simply means transference on the part of the analyst. However, I would suggest that the prefix 'counter' implies additional factors. (p.81)
>
> My thesis is that the analyst's emotional response to his patient within the analytic situation represents one of the most important tools for his work. The analyst's countertransference is an instrument of research into the patient's unconscious. (p.81)
>
> The analytic situation has been investigated and described from many angles, and there is general agreement about its unique character. But my impression is that it has not been sufficiently

> stressed that it is a relationship between two persons. What distinguishes this relationship from others, is not the presence of feelings in one partner, the patient, and their absence in the other, the analyst, but above all the degree of the feelings experienced and the use made of them, these factors being interdependent. The aim of the analyst's own analysis, from this point of view, is not to turn him into a mechanical brain which can produce interpretations on the basis of a purely intellectual procedure, but to enable him, to sustain the feelings which are stirred in him, as opposed to discharging them (as does the patient), in order to subordinate them to the analytic task in which he functions as the patient's mirror reflection. (pp.81-82)

Heimann's conceptualization is exciting, for if the therapist's task is to sustain countertransference feelings for use in the treatment situation, then not only are these reactions normal, they are indeed useful. Heimann discussed and then illustrated (with a case example) the diagnostic use of countertransference.

> I would suggest that the analyst along with this freely working attention needs a freely roused emotional sensibility so as to follow the patient's emotional movements and unconscious phantasies. Our basic assumption is that the analyst's unconscious understands that of his patient. This rapport on the deep level comes to the surface in the form of feelings which the analyst notices in response to his patient, in his 'counter-transference'. This is the most dynamic way in which his patient's voice reaches him. In the comparison of feelings roused in himself with his patient's associations and behaviour, the analyst possesses a most valuable means of checking whether he has understood or failed to understand his patient. (p.82)

After cautioning that intense emotions will blur judgment and observation Heimann suggested that

> ...the analyst's emotional sensitivity needs to be extensive rather than intensive differentiating and mobile. There will be stretches

> in the analytic work, when the analyst who combines free attention with free emotional responses does not register his feelings as a problem, because they are in accord with the meaning he understands. But often the emotions roused in him are much nearer to the heart of the matter than his reasoning, or, to put it in other words, his unconscious perception of the patient's unconscious is more acute and in advance of his conscious conception of the situation. (p.82)

Although she attempted to use countertransference responses diagnostically, her attempts were not well developed. She believed that we may come to the point where we can work out the way in which the nature of the countertransference corresponds to the nature of the client's unconscious impulses and defenses operative at the time. Heimann noted that

> ...the analyst's immediate emotional response to his patient is a significant pointer to the patient's unconscious processes and guides him towards fuller understanding. It helps the analyst to focus his attention on the most urgent elements in the patient's associations and serves as a useful criterion for the selection of interpretations from material... the analyst's countertransference is not only part and parcel of the analytic relationship, but it is the patient's <u>creation</u>, it is a part of the patient's personality. (p.83)

In addition to the diagnostic utility of countertransference reactions, there is another important aspect to their use, viz, does one use one's countertransference reactions by revealing them, and if so, under what circumstances, to whom, and how? It may be recalled that some writers such as Ferenczi advocated the therapist's open expression of feelings towards the client so as to make the therapist more human, more reachable. Heimann took exception to this. She believed that

such communication is tantamount to a confession, and would be a burden to the client; the client's feelings would be deemphasized.

Heimann published her short and profound article in 1950. There were several responses to it in the literature. In 1960, Annie Reich attacked Heimann's view, and suggested that Heimann had described a pathological reaction and a failure in empathy and understanding, not a sensitive tool for comprehending the client's material. (p.41) Margaret Little also took issue with Heimann. Little published three important papers on countertransference: one in 1951, another in 1957 and one brief panel presentation (1960). Focusing mainly on severely disturbed clients, Little recommended that the therapist admit an error to the client and, unless contraindicated, explain its origin in the therapist's unconscious countertransference.

Little's articles deal with the phenomenon in its many aspects. She explored the source of countertransference, defined it, and evaluated its influence on treatment (she saw it as both a detriment and as an enhancer). She discussed the nature of the mechanisms of countertransference and the therapeutic handling of countertransference, and explored the alternate terms, finding the term itself too limiting. What a contrast, this article, to those written 20 and more years earlier! It foreshadows the writings to come. It stands as a watershed between the perception of the therapist as mere reflector, and the energetic exploration of interaction between therapist and client.

Little's first two articles were written six years apart and together comprises a comprehensive work. Initially, she organized and reviewed the various definitions of countertransference, and discussed

the difficulties she encountered in the process of evolving a definition. Later (1957), she changed the terminology, introducing a symbol called "R".

> ...Besides the confusion between these various meanings the term 'countertransference' has also come to be invested with an emotional charge, which makes discussion difficult. It is obviously impossible to avoid either the confusion or the emotional charge altogether, but to reduce both to a minimum I am introducing a symbol, R, to denote what I am talking about, defining it as the analyst's total response to his patient's needs, whatever the needs, and whatever the response.
>
> R, then, includes all that is conscious, and all that is unconscious, what is unconscious consisting of what is repressed (whether normally or pathologically), and much besides that has never been conscious. In other words, it includes things belonging both to the analyst's ego, his superego, and his id... and it will be seen that 'countertransference' is then part, only, of what I have called R. (pp.240-241)

Little was not the only clinician to try to establish new terminology for countertransference. The effort started as early as Glover (1928). There were at least half a dozen other attempts, including (during the fifties and some more recent work), Jackson (1956), Spitz (1956), Margolis (1978), Grinberg (1962), R. Fleiss (1953), and Sandler (1976). They will be discussed in a following section of this review.

In her earliest of the three papers, Little (1951) had encountered difficulties in defining countertransference. She attributed these difficulties to four problem areas:

1) The basically unconscious nature of countertransference and consequent impossibility of observing it directly;

2) the difficulty in distinguishing countertransference attitudes from other aspects of the therapist's attitudes;

3) her perception that countertransference is an integral part of the transference, i.e., that the countertransference is inseparable from the transference;

> ...transference and countertransference are inseparable; something which is suggested in the fact that what is written about the one can so largely be applied to the other. (p.34)

4) what she perceived as a common paranoid or phobic attitude toward the therapist's subjective feelings.

> ...I think there is an attitude towards countertransference, i.e., towards one's own feelings and ideas, that is really paranoid or phobic, especially where the feelings are or may be subjective... In any case, what is unconscious one cannot easily be aware of (if at all) and to try to observe and interpret something unconscious in one-self is rather like trying to see the back of one's own head - it is a lot easier to see the back of someone else's. The fact of the patient's transference lends itself readily to avoidance of (countertransference) by projection and rationalization, both mechanisms being characteristic for paranoia, and the myth of the impersonal, almost inhuman analyst who shows no feelings is consistent with this attitude. (p.33)

Here, Little was discussing some of the resistance to the exploration of countertransference phenomena.

Despite the difficulties attributed to the process of conceptualizing the phenomenon, Little arrived at a definition of countertransference in this earlier article, which foreshadowed her later definition of R:

> The whole patient-analyst relationship includes both 'normal' and pathological, conscious and unconscious, transference and countertransference, in varying proportions; it will always include something which is specific to both the individual patient and the individual analyst. That is, every countertransference is different from every other, as every transference is different, and it varies within itself from day to day, according to variations in both patient and analyst and the outside world. (p.33)

What a liberating definition! In Little's view, countertransference is a living part of the therapeutic relationship, changing from day to day and event to event. If this be so, then the use of countertransference must be valuable. She speculated:

> I wonder whether failure to make use of countertransference may not be having a precisely similar effect as far as the progress of psychoanalysis is concerned to that of ignoring or neglecting the transference; and if we can make the right use of countertransference may we not find that we have yet another extremely valuable, if not indispensable tool? (p.33)

In 1960, in a panel discussion with Winnicott, Heimann, and Fordham, Little focused on the positive contribution of countertransference reactions and upon countertransference responses to unpredictable patients. She defined countertransference as "the specific part of the analyst's total response to his patient's needs that has remained unconscious and under repression" (p.29) and concluded that:

> countertransference is a fact of analysis, and as such it is essentially neutral, or rather perhaps, ambivalent. That is, it is potentially both good and bad, valuable and harmful. But far more than that; those very experiences of infancy and childhood, whose memories are so important to us, provide the possibility of our understanding our patients. (p.31)

The importance of this 1960 paper is that Little examines the very different effect on the therapist of two categories of clients: neurotics and "patients whose behavior and reactions are unpredictable." She noted that "the affects and anxieties aroused in the analyst by patients of the two types are different, both in quantity and quality. (p.29)

> But with patients whose reactions and behaviour are unpredictable it is another matter. The quantity of affect that is aroused suddenly can be very great, on occasion; the outcome of the treatment may remain in doubt for a very long time, and the type of anxiety aroused in the analyst, apart from his objective anxiety, is often largely psychotic anxiety... (p.29)

As if she had anticipated the therapist's response, Little went on to say:

> ...what are 'interpretations' to the analyst are often merely meaningless remarks to the patient...and next time he will behave exactly as if he had never heard the interpretation...he will frequently present the analyst with a situation which does not allow time enough for this examination and sifting to happen before some remark or action must be made to forestall him in some way, if a dangerous piece of acting-out is not to happen. Whatever the analyst says or does in these circumstances must have some interpretative effect, as far as the patient is concerned; that is, it must convey to him something of reality which he had been unable to perceive for himself. Fortunately, for these patients, many things of which we are ordinarily unaware have such an effect and if we are willing to let them happen, the results are often very enlightening to us as well as to our patients. (p.29)

Little then described a patient in a state of frenzy about to smash a flower pot in her office, together with her own reaction:

> I was only aware of sudden anger, which was expressed before I knew it. (I had had many of these episodes of frenzy with her without reacting. The emotion had been sustained, and I was pretty tired of them by then and so was she.) I said, 'I'll just about kill you if you smash my pot.' There was a sudden silence, which lasted quite a time, and I then said, 'I think you thought I really would kill you, or perhaps that I had done so.' She said, 'Yes, it felt like that, it was frightful; but it was also very good. I know you really felt something, and I so often thought you didn't feel anything at all...' (p.30)

She then discussed her response:

> ...the unconscious part of the ego <u>does</u> function as ego, albeit appearing in id fashion, sometimes; that it exerts some control over id impulses (for I only <u>spoke</u> of killing her and would not have done so), and that it can be relied on... The unpredictable reactions that are provoked by the behavior of such a patient as this are in fact met by the ego as well as by the id. The superego should have no part to play, and where it does, it does so as part of the id, rather than as part of the ego, and this, again manifests unconscious counter-transference. (p.30)

This example gives life to the recommendations made in Little's 1957 paper, that the therapist communicates reactions to severely disturbed patients. The therapist must feel free to react, even primitively and spontaneously when appropriate, for this kind of patient needs to experience the therapist as one with whom it is possible to have human contact. Little believed it essential for such patients to learn that therapists have limits also, sometimes also need to discharge tension, and that it can be done safely. Little advised further that the only way to relieve a patient's paranoid anxiety is to allow him or her to experience the therapist as a human being, that is to say a limited being.

It is the countertransference which often has to do the work. Not only does the therapist hold up a mirror to the patient, but the patient in turn holds one up to the therapist. The patient often becomes aware of real feelings in the therapist even before the therapist is aware of them. "What comes (from the patient) may on occasion be a piece of real countertransference interpretation for the analyst." (1951, p.39)

Thus Little, as did Winnicott, viewed the use of countertransference responses as a valuable adjunct to the therapeutic process--more, as an integral part. While Heimann believed that one should not communicate one's countertransference feelings, Little's writings indicate that it might well be impossible not to do so, for consciously or unconsciously, the therapist's feelings are communicated to the client and the client uses them in order to gain the experience of a human interaction. Although she did not use the term, Little described what later came to be called "induced" countertransference feelings. Spotnitz (1969), Searles (1958, 1978) and Epstein (1979) elaborated Little's views, recommended that therapists selectively communicate induced feelings to schizophrenic and borderline clients. The issue of what is an induced feeling and how to distinguish it from other forms of countertransference will be addressed shortly.

The work of Heinrich Racker (1968) was the most comprehensive of all the seminal writers. His papers concerning countertransference appeared in English between 1953 and 1958, the Spanish originals somewhat earlier. His writings were collected into a single volume, Transference and Countertransference, published posthumously in 1968.

He focused on the use of countertransference reactions for diagnosis, not for self revelation. So significant is Racker's work that it is allotted a separate chapter in this work.

Although these four writers (Heimann, Little, Racker, and Winnicott) influenced the prevalent view of countertransference, by no means was there agreement within the realm of analytic writers. Annie Reich was the foremost and most eloquent of the writers propounding the classical position. She published three papers on countertransference in 1951, 1960 (mentioned earlier), and 1966. Her position remained essentially unchanged through the 15-year span. Reich took a position decidedly at odds with the "seminal four." She firmly rejected the notion that countertransference can be used as a therapeutic aid, either for communication or as data for the understanding of the client. In effect, Reich accused Heimann of converting a fault into a virtue. In so doing, Reich overlooked Heimann's insight perhaps because Heimann's affective knowledge was running ahead of her conceptual knowledge. Reich made several points, repeatedly, and adamantly. She understood countertransference as only the unconscious pathology of the therapist.

> ...Countertransference thus comprises the effects of the analyst's own unconscious needs and conflicts on his understanding or technique. In such cases the patient represents for the analyst an object of the past on to whom past feelings and wishes are projected, just as it happens in the patient's transference situation with the analyst. The provoking factor for such occurrence may be something in the patient's personality or material or something in the analytic situation as such. This is countertransference in the proper sense. (1951, p.26)

Some inconsistencies appear in Reich's formulation. For example, she wrote of countertransference as a "prerequisite" of psychoanalysis, saying:

> ...Countertransference is a necessary prerequisite of analysis. If it does not exist, the necessary talent and interest is lacking. But it has to remain shadowy and in the background. This can be compared to the role that attachment to the mother plays in the normal object choice of the adult man. Loving was learned with the mother, certain traits in the adult may lead back to her - but normally the object can be seen in its real character and responded to as such. A neurotic person takes the object absolutely for his mother or suffers because she is not his mother.
>
> In the normally functioning analyst we find traces of the original unconscious meaning of analysing, while the neurotic one still misunderstands analysis under the influence of his unconscious fantasies and reacts accordingly. (1951, p.31)

Reich then narrowed her definition of what is countertransference. She distinguished between what she called countertransference (wholly unconscious) and empathy and trial identification. She seemed to accept Deutsch's formulation regarding empathy, yet attacked the idea of its therapeutic usefulness. She did not distinguish between the use of countertransference in an impulsive, direct discharging fashion and the use of countertransference responses as an inner experience, to be harnassed in order to clarify, understand, scrutinize, and enhance the therapeutic process. Indeed, she rejected intense countertransference experiences, assigning them to the realm of the pathological.

> A neutralized cathexis of the patient is never relinquished. Thus, the analyst never loses sight of the patient as a separate being and at no time feels his own identity changes. This enables him to remain uninvolved. (1960, p.391)

Reich's use of the words "never" and "at no time," is rather strong language. It underscores the intensity of her belief that the therapist may never have intense emotional reactions to a client. Reich has remained the strongest opponent to the view of countertransference as a potential therapeutic ally.

Writing in 1952, Mabel Cohen also broke with tradition and further opened the door for the writings that were to follow. She offered an operational definition of countertransference:

> When, in the patient-analyst relationship, anxiety is aroused in the analyst with the effect that communication (verbal or behavioral) between the two is interfered with by some alteration in the analyst's behavior, then countertransference is present. (p.235)

Thus, if one becomes aware of not hearing the client well, or of being diffuse for example, one can assume the presence of some countertransference reaction and then begin to explore its meaning.

Cohen, as did Winnicott, identified three sources of countertransference:

1) situational factors; that is, reality factors such as the need for success and recognition in the therapist, as a competent professional;

2) unresolved neurotic conflicts of the therapist;

3) communication of the client's anxiety to the therapist.

She recognized, as did Winnicott, that the therapist is emotionally affected by the client, i.e., that Annie Reich's uninvolved therapist is a myth. Thus, with the exception of Reich's writings which represents the classical position, the focus of countertransference thinking shifted during the decade of the fifties. It became possible to review the

literature in terms of the specifics which the authors addressed. Most of the new writings discuss the phenomenon from a variety of aspects, as Little's writings do. Trends in patterns of perception, conception, and interpretation are discernible. A number of issues seemed common to almost all of the literature, and out of these emerge three major focal areas:

1) the definition of countertransference: a) its origin and cause and b) its nature and mechanisms;

2) the function of countertransference: the handling of it within the process, and whether or not to reveal it; and

3) the author's attitude towards countertransference as a phenomenon, i.e., whether a detriment or an aid.

The balance of the literature will be reviewed topically rather than, as heretofore, chronologically.

THE DEFINITION OF COUNTERTRANSFERENCE

A) Its Origin and Cause

Through the latter part of the almost 70-year period of scholarly work reviewed for this paper, authors have disagreed on what constitutes countertransference. The controversy began in 1939 with the Balints. It increased sharply during the fifties. The writers during that decade seemed to have no difficulty defining countertransference individually, they only had difficulty agreeing among themselves on its definition. Some authors identified different causes of countertransference, the underlying assumption being that different kinds of countertransference exist. The effect was profound. No longer was the assumption made that

all countertransference is alike and detrimental to the treatment process. Douglass Orr noted the trend in 1954:

> It will be noted in the references already cited that there is an explicit or implied difference in the concept of countertransference as simply a reaction to the patient's transference as distinguished from the analyst's own transference to the patient for whatever reasons and arising from his own unresolved neurotic difficulties. This distinction becomes a persistent theme in later contributions. (p.648)

Most authors writing about countertransference now concentrated their attention on its genesis and its definition. The two areas overlap. Primary attention focused on whether countertransference derives from the conscious, from the unconscious, or from both. The earlier writers understood countertransference as unconscious. The later writers are not as clear, since their definition of countertransference is so broadened. It seems that the more accepting one is of the concept of countertransference, the more one applies it to wider spheres.

The view that the majority of post-1950 writers hold is of countertransference as a product of both conscious and unconscious material. However, there are some writers who still understood it as deriving primarily from the therapist's unconscious. Writing in 1956, Lucia Tower took the stance that countertransference reactions derive from the unconscious and cannot directly be known. She reviewed the work of numerous authors, quoted from Sharpe, Berman, Glover, Fleiss, Little and Alexander regarding the therapist's ability to control countertransference reactions, and then commented:

> All of these - and similar attitudes - presuppose an ability in the analyst consciously to control his own unconscious. Such a supposition is in

> violation of the basic premise of our science - namely, that human beings are possessed of an unconscious which is not subject to conscious control, but which is (fortunately) subject to investigation through the medium of the transference (and presumably also the countertransference) neurosis. (pp. 226-227)

Charles Savage (1961) agreed:

> Since countertransference, as I have defined it, is unconscious, it cannot be observed directly but can only be inferred from its effects on the conscious attitudes, feelings, perceptions and behavior of the analyst. (p.53)

These authors' positions are rather close to the position taken by those who hold with the more traditional view of countertransference: that countertransference reactions are unconscious and derive from the therapist's transference response to the client. Lucia Tower (1956) wrote:

> I would employ the term countertransference only for those phenomena which are transferences of the analyst to his patient. It is my belief that there are inevitably, naturally and often desirably, many countertransference developments in every analysis (some evanescent - some sustained) which are a counterpart of the transference phenomena. Interactions (or transactions) between the transferences of the patient and the countertransferences of the analyst, going on at unconscious levels, may be - or perhaps always are - of vital significance for the outcome of the treatment. (p.227)

Maxwell Gitelson (1952) tried to distinguish countertransference from the analyst's transference:

> It is my impression that total reactions to a patient are transferences of the analyst to his patients and are revivals of ancient transference potentials. These may be manifested in the overall attitude towards patients ...or may exacerbate in the 'whole response' to particular patients...may be positively or negatively toned. (p.6)

> ...In contrast, countertransference arises in response to:
>
> 1) the patient's transference, 2) the material that the patient brings in, and 3) the reactions of the patient to the analyst as a person. (p.6)

Nowhere in his paper does Gitelson indicate that countertransference is diagnostically or therapeutically useful vis a vis the client. In fact, although Gitelson sees countertransference reactions as "a part of the dynamic and economic problem in every analysis" (p.10), he seems to see these reactions as defenses and their analysis as helpful to the therapist's self-understanding:

> A countertransference reaction, if the analyst is 'open' enough to analyze it, can be an integrative experience along the road of interminable analysis. For such reactions seem to be defenses against what the analyst discovers of himself in and through the patient. (p.7)

As might be anticipated, inquiries into the wellsprings of countertransference gave rise to new definitions. Heimann's definition had included all the feelings which the therapist experiences towards the client. Little's definition was also broad, including normal and pathological, conscious and unconscious, in varying proportions.

Maltsberger and Buie (1974) included transference responses in their definition of countertransference, but did not so limit it. They understood countertransference as growing out of the individuals involved, as well as out of the relationship between them:

> Countertransference is inevitable in all psychotherapies. Taken in the broader sense of the term, it comprises the therapist's emotional response to his patient's way of relating to him, and to transference which the therapist may form in relation to his patient. Some of the therapist's countertransference response may specifically arise from the way the patient behaves in the

> specific therapeutic relationship, and some of it may stem from the disposition of the therapist to react in certain ways whether to all patients or to patients of a certain type. (p.625)

Their definition does not allow for the effect of the client's material on the therapist. It focuses on the interaction between the two. They did not discuss empathy or empathic identifications within the realm of countertransference. However, if one assumes that their definition covers positive as well as negative responses, then it includes the range of identifications.

Harold Searles (1979) distinguished between empathic identifications and what he called neurotic countertransference.

> I concur with Rosenfeld's well-stated emphasis upon the importance of distinguishing between neurotic counter-transference on the analyst's part and 'counter-transference' that is essentially an empathic experiencing of feelings communicated from the patient. (p.364)

Orr (1954) noted that any discussion of the technical handling of countertransference inevitably varies according to what one believes is the cause of the countertransference experience:

> Is countertransference simply the analyst's response to the patient's transference, and does this mean the conscious response, his unconscious response or both? Or does it mean the analyst's transference reactions to the patient, whether to his transference, to other attributes of the patient or to the patient as a whole? Or, does countertransference include all attitudes and feelings of the analyst toward the patient whatever they are and whatever may give rise to them? Does it also include attitudes consciously assumed or roles deliberately planned and enacted in order to effect a corrective emotional experience? Does it, indeed, as the Balints suggest, comprise everything the analyst brings to the analytic situation - his office, his technique and all that he was, is and ever hopes to be? (pp.657-658)

Sandler, Holder and Dare (1970) initially found the classical thinking too restricting.

> Undoubtedly the restriction of the clinical concept of countertransference to the analyst's transference to his patient provides us with too narrow a definition, and one which is too closely tied to the particular meaning attributed to transference...it would seem appropriate to take into account the useful extension of the concept to include those aspects of the analyst's emotional responses to his patient which do not lead to 'resistances' or 'blind spots' in the analyst, but which may be employed by him as a means of gaining insight ...into the meaning of the patient's communications and behaviour. (pp.86-87)

To these writers, broadening the term renders it meaningless, diminishing the precision with which it is used. They discerned six main elements of countertransference in current use at the time of their writing.

> 1)'Resistance' in the analyst due to the activation of inner conflicts in him... producing blind spots (Freud, 1910, 1912)
>
> 2) The 'transferences' of the analyst to his patient (Reich, 1951, 1960)
>
> 3) The disturbance of communication between analyst and patient (Cohen, 1952)
>
> 4) Personality characteristics of the analyst which are reflected in his work and which may or may not lead to difficulties in his therapy (e.g., Balints 1939); or the whole of the analyst's conscious and unconscious attitudes to his patients (Balints, 1950)
>
> 5) Specific limitations in the psychoanalyst brought out by <u>particular patients</u>; also the specific reaction of the analyst to his patient's transference (Gitelson, 1951)
>
> 6) The 'appropriate' or 'normal' emotional response of the analyst to his patient. This can be an important therapeutic took (Heimann, 1950, 1960;

> Little, 1951), and basis for empathy and understanding (Heimann, 1950, 1960; Money-Kyrle, 1956)

Kenneth Frank (1977) identified two schools of thought about countertransference. One he designated the classicist; it includes Glover, Reich and Fleiss. The other he called totalist, or modernist, a school represented by Fromm-Reichman, Racker and Winnicott, among others. To Frank, the totalist or modernist designation covers a broader view of countertransference that includes the classical interpretation but is not limited to it. The totalist's define countertransference

> ...as the analyst's total emotional response to the patient in the psychoanalytic situation, including conscious as well as unconscious reactions...It also provides for responses to the reality of the patient, as well as to his transference, includes responses originating from the analyst's realistic as well as neurotic needs. (pp.4-5)

Frank differentiated the ways in which the schools view the use and disposition of countertransference responses, ways which were based on their differing views of its cause. The classicists emphasize the need for resolution of countertransference and minimize its usefulness. The totalists believe that while countertransference is to be resolved, it is clearly useful to an understanding of the client. The article points out that the modernist view gives the therapist permission to accept and utilize subjective reactions to the client. Discussing the therapist's responses, Frank said:

> They are in effect legitimized, thus releasing a fuller psychotherapeutic potentiality...Far more importantly, it marks the movement within psychoanalysis toward a fuller recognition of the

> psychoanalyst as an involved person, rather than as a detached technician or an omniscient being, and of the essential human core of psychoanalytic endeavor. (p.5)

Thus, Frank summarized the trend in psychotherapy towards a shifting view of the origins and causes of countertransference phenomenon.

Benjamin Margolis (1978) evolved a mini model of countertransference, which resembles Racker's in its structure. Margolis designated some of the therapist's reactions as "induced countertransference feelings." His definition of the term is those "reciprocal feelings which the patient's transference feelings have induced in the analyst both by emotional contagion and through an act of identification by the analyst...the analyst finds himself in emotional resonance with the narcissistic patient..." (p.138)

Margolis distinguished between objective and subjective countertransference. He described objective countertransference and contrasted it to subjective countertransference:

> Objective and subjective countertransference alike run the gamut of emotions, from the mildest to the most intense. Objective countertransference is usually limited in time to the span of the analytic session. Once the patient leaves, the analyst is open to a fresh set of impressions from the next patient. By contrast, a characteristic of subjective countertransference is often its prolongation far beyond the session...Another distinguishing characteristic is that of acting out. The analyst who, forsaking his analytic role, acts on his feelings toward the patient, has yielded to the exigencies of his own unresolved conflicts, and is by definition experiencing subjective countertransference. (p.139)

An interesting feature of Margolis' formulation is that the therapist can diagnose the presence of countertransference from his or her actions and discomfort, and then use that "symptom" diagnostically to acquire further understanding of the patient. Margolis' understanding is that, fundamentally, countertransference is the product of an act of identification by the therapist.

In the controversy over the source of countertransference, there seems to be an oscillation between the Scylla of a too-narrow view and the Charybdis of one so broad that a meaningless souffle results. Perhaps the difficulty lies with the terminology. Many authors complain about the term. Some find it too opprobious and confining, others too broad and all-encompassing. Still others use "countertransference" to mean one aspect of the concept, while searching for another word to apply to the rest of the concept. The renaming attempts began as far back as Glover (1928), when he distinguished between counter-resistance and countertransference.

Beginning with the fifties, most theoreticians recognized that neurotic countertransference is only one part of the therapist's dynamics in the therapeutic process. Another term was needed for the non-neurotic component. There was no concise way to communicate this other aspect--the aspect which Searles referred to as an empathic experiencing of feelings emanating from the client, which Racker called concordant and complementary identifications, and which Sandler called role responsiveness. The old term empathic identification did not seem to be a usable communicative tool. There is considerable agreement that the therapist's part of the interaction

overflows the bounds of the traditional conceptual structure known as countertransference. But no new term caught on which could convey the richness of the process.

Don Jackson (1956) suggested using the word "palintrophy" or "palintropic processes." He felt that term would allow the inclusion of all the processes occuring between two people. He liked the term. It literally suggested to him a going back and forth between client and therapist and does not start with the client, as the prefix "counter" implies. He wanted the term to be used in conjunction with countertransference. To Jackson, countertransference rests more with the therapist than with the client, and ideally can be managed by the therapist. It does not have to exist. Palintrophy, on the other hand, "would necessarily exist since there are two people in therapy." (p.236)

Jackson recognized that the therapist's feelings can emanate from two sources: from the client and from the interrelationship between the two people. These were two different kinds of counter-transference feelings to Jackson, and he recommended treating them differently.

Jackson's separation is similar to Margolis' (1978) model. That is, Jackson differentiated between "induced" countertransference and "neurotic" countertransference, although at the time of Jackson's writing, the terms used in that way had not yet been introduced.

Rene Spitz (1956) understood countertransference in the traditional sense, i.e., as deriving from the therapist's unconscious reactions to the client. He agreed with Annie Reich in viewing it

as a normal phenomenon, always present, originating in the therapist and revealing of the therapist's dynamics. Since this was Spitz's view of countertransference he needed to invent another word to account for the other feelings the therapist experiences towards the client. He suggested the term "diatrophic," which, in his description seems to be equivalent to what might be called a parental attitude or identification toward the client.

> The diatrophic relation begins with an identification fantasy, but with progressive development will end up in the reality situation of the subject becoming himself a parent. (p.261)

Spitz, too, wanted the terminology to distinguish between the therapist's benign identifications and neurotic ones.

By the early '60's so many attempts to rename countertransference had been made that Ross and Kapp (1962) reviewed the separate terminologies:

> The separate definitions of countertransference have led several authors to use other terms to label some of the related phenomena which do not fit with the more usual specific transference, or the analyst's unconscious transference to the patient. Some of these terms are: 'counterresistance' (Glover and Racker), 'counteridentification' (R. Fleiss), 'the emotional position of the analyst' (Gitelson, 'R' (the analyst's total response to his patient's needs) (Little), 'normal countertransference' (Money-Kyrle), 'the experiences of the analyst' (Szasz), and 'the analyst's personal equation' (Azorin). (p.644)

None of the suggested terms is in use today; none of them ever made an impact. Why could no agreement be reached? Why for instance was there no agreement to limit the term countertransference to that which is transferred from the therapist, both neurotic and non-neurotic?

It seems that countertransference evokes a variety of resistance difficult to analyze, impossible to defy. Initially there was resistance to the exploration of the concept. Now we find resistance to accepting a universal definition or a universal way of designating the phenomenon (or phenomena). Perhaps the problem is that the term was named by Freud, the founding father of psychoanalysis, and that there is no longer any single individual with either the stature or the authority to make such change.

One final aspect of the discussion is that of the role of the real relationship. The early ideal was of the therapist as a blank screen, of the impartial and scientific observer unaffected by the vicissitudes of the therapeutic relationship. There was debate whether a "real" relationship existed, or whether all aspects of the relationship were to be understood as manifestations of the transference. More recently, interest centered on the role of the real relationship in treatment, on countertransference reactions, and on distinguishing between them. The following authors all acknowledge the existence of a real relationship and its value in treatment. Each of them approaches the issue differently.

Janet Rioch (1943) described as "the neatest trick of the week!" (p.96) the idea that a therapist could act as a mirror. She believed there is no such thing as an impersonal analyst and said that "whether intentionally or not, whether conscious of it or not, the analyst does express, day in and day out, subtle or overt evidence of his own personality in relationship to the patient." (p.96)

Fromm-Reichmann (1949) described the value of the real relationship to the client and to the therapist, attributing to it the

therapist's ability to sustain the client's emotional reactions. Edith Weigert (1954) posited a polarity between transference and the real relationship. Without explicating her remark, she said that the tension resulting from this polarity coincides with what she described as ideal positive countertransference.

Wright (1952) and Racamier (1959) each discussed the real relationship specifically with regard to the psychotic client. Each concluded that the therapist's awareness of and attention to the real relationship makes it possible for the client to progress.

Anna Freud (1968) believed that the real relationship to the therapist is never wholly submerged.

> With due respect for the necessary strictest handling and interpretation of transference, I still feel that somewhere we should leave room for the realization that analyst and patient are also two real people, of equal adult status, in a real personal relationship to each other. (p.373)

Racker (1968) agreed and expanded upon Anna Freud's comments:

> The first distortion of truth in the 'myth of the analytic situation' is that analysis is an interaction between a sick person and a healthy one. The truth is that it is an interaction between two personalities, in both of which the ego is under pressure from the id, the superego and the external world... (p.132)

Winslow Hunt (1978) wrote that:

> ...the analyst is, or should be in continuous tension between his participation in a human relationship, experiencing all the feelings which that participation requires...and his therapeutic purpose, to use that relationship to understand and help... (p.455)

Therese Benedek (1953) found a close correlation between the real relationship, the therapist's ability to tolerate it, and countertransference manifestations. She argued that the resistance to the study of countertransference developed in the service of maintaining the therapist's non-involvement in the therapeutic field. For Benedek, the counterpart to the therapist's abstinence and neutrality was the implicit assumption that the client was not supposed to sense and discern the therapist as a person, an impossibility to her.

> The patient, under the pressure of his emotional needs...may grope for the therapist as a real person, may sense his reactions and will sometimes almost read his mind. (p.203)

Benedek logically posited in her theory that the way in which the therapist responds to being recognized by the client constitutes the key to many countertransference situations.

Thus, the analytic perception of the "real relationship" has undergone an evolution from the former denial of its existence in the therapeutic relationship, to the present understanding of it as an important part of the working relationship and an important contributor to the therapist's countertransference.

B. Countertransference Mechanisms

What psychic mechanisms are involved in the creation of counter-transference responses? For many years the question was hardly an issue. Countertransference derived from the therapist's repressed libidinal urges; the id and the superego were involved. Later writers, who accepted countertransference as a necesary and integral part of the therapeutic interaction, began to explore its nature more

rigorously. They theorized about the mechanisms involved. The primary mechanism seems to be identification. The term encompasses a number of processes variously called parental identification, partial identification, introjection and projective identification. Lewin (1946) and Margolis (1978) each believed that identification is the chief mechanism involved in countertransference. Margolis went so far as to designate all forms of countertransference as "fundamentally the product of an act of identification by the analyst." (p.134)

Other authors preferred to narrow the concept.

Rene Spitz (1956) believed that the client's helplessness in the analytic setting provide the situational stimulus for the therapist. This helplessness "evokes in the analyst fantasies derived from the ego ideal which he formed in identification with his parents." (p.260) Spitz believed that this act of parental identification forms the seed of the countertransference.

Money-Kyrle (1956) credited the therapist's partial identification with the client for the ability to experience empathy and insight. This projection contains both introjective and projective aspects. When the therapy goes well, the therapist experiences a rapid oscillation between these aspects. However, the therapist is most likely to be aware of the projective phase, that is, the phase in which the client represents an illresolved or immature aspect of the therapist. It can be troublesome. Money-Kyrle defined normal countertransference as the therapist's ability to "be concerned for the welfare of his patient without becoming emotionally involved in his conflicts." (pp.360-361)

For Weigert (1954), the mechanism of introjection is the basis for countertransference as well as the basis for an uninhibited understanding of the client.

Bryce Boyar (1979) took it for granted that introjection is the chief mechanism for countertransference. In an unpublished paper, he accounted for the therapist's increased countertransferential involvement with regressed clients by explaining that "...the combination of the regressed patient's tendency to use defenses which involve projection and the introjective aspects of counter-transference contributes heavily to the greater countertransferential involvement of therapists while working with regressed rather than neurotic patients." (p.3)

Rosenfeld (1977) also saw introjection as the dominant source of countertransference.

Grinberg (1962) and Segal (1972) identified projection as the chief mechanism involved.

One thread that emerges is that those therapists who specialize in work with primitive disorders are more cognizant of the effect of the client's projections on the therapist's feelings. Such thinking is evidenced from Ferenczi (1919) through Fromm-Reichmann (1950), Little (1951), and Winnicott (1949) and is currently seen in the work of Searles (1979), Boyar (1979), Hoedemaker (1967), Kernberg(1975), and Kohut (1978).

In the attempt to understand the psychological underpinnings of the countertransference phenomenon, various mechanisms have been identified as essential or contributing components. The early,

classical writers focused on the mechanism that related to the therapists' own transference to the client; i.e., repression. Later writers discussed mechanisms which attended more to the interactional process and the real effect of the client on the therapist which was accentuated by the therapist's wish to be open to experiencing the client. The various aspects of identification became the prime focus.

FUNCTION OF COUNTERTRANSFERENCE

How does countertransference function in treatment? There are various views. It functions as an enhancer of the treatment process, as "sublimated and decathected". (Reich, 1951) It functions to interfere with the treatment process. It functions as a source of empathy. (Robinson, 1968) It has an informative and therapeutic function. (Jackson, 1954). It is significant to the outcome of treatment. (Tower, 1958) It functions to give information about the client, the therapist, the interaction between the two. (Spotnitz, 1969, Racker,1968) It even functions to keep the therapist involved. (Racamier, 1959)

Given then, that countertransference is a necessary component of treatment which both enhances and deters the treatment process, the next issue would be, how should countertransference be handled?

Throughout the literature, there is universal agreement on one issue--that the therapist must constantly be aware and vigilant. In the traditional view, therapists use countertransference responses to further their understanding of themselves and of their unconscious processes.(Fenichel 1945, Glover 1927, Fleiss 1953, and Little 1957)

Another group of therapists sees the countertransference as a source of insight into the therapeutic process, most notably Fromm-Reichmann (1950), Hora (1956), Benedek (1953), Freebury (1978), Sandler (1970, 1976) and Ross (1962). Still others see countertransference as a key to the client's unconscious. This takes us back to Freud (1912), who believed it possible for one unconscious to know the other--a meeting of the unconscious, as it were. Maltsberger and Buie (1974) commented on this:

> When countertransference is fully conscious it can stimulate the introspection in the therapist, can usually be controlled, and can direct his attention to details of his patient's behavior the meaning of which might otherwise remain obscure. Otherwise, when unconscious, countertransference may generate well rationalized but destructive acting out by the therapist. (p.625)

Unfortunately, the authors do not let the readers know how to make the countertransference fully conscious. Perhaps it is possible to utilize Mabel Cohen's (1952) series of signals through which the therapist can become aware of such difficulties. Although her list is quite long, it includes such clues as an inability to identify with the client, overemotional responses, unreasonable like or dislike for the client, drowsiness, arguing, defensiveness, etc. These responses, taken as signals, can clue the therapist to the existence of a countertransference reaction although it may be specifically identified.

Rosenfeld (1964) discusses the use of the therapist's counter-transference in work with psychotic clients:

> In my opinion the unconscious intuitive understanding by the psychoanalyst of what a patient is conveying to him is an essential factor in

> all analyses, and depends on the analyst's capacity to use his countertransference as a kind of sensitive 'receiving' set. In treating schizophrenics who have such great verbal difficulties, the unconscious intuitive understanding of the analyst, through the countertransference is even more important, for it helps him to determine what it is that really matters at the moment. But the analyst should also be able to formulate consciously what he has unconsciously recognized and to convey it to the patient in a form that he can understand. This after all is the essence of all psychoanalysis... (p.76)

Although considerable discussion in this dissertation has already focused on the negative aspects of countertransference, some attention needs to be paid to the body of literature written specifically about the countertransference difficulties encountered when working with severely disordered individuals. It is commonly recognized that these patients evoke and provoke responses in the therapist that are substantively different from those evoked by more neurotically structured individuals. The issue of the therapist's unresolved libidinal struggles seems not to pertain to this population.

Silvano Arieti (1955) stated this idea succinctly:

> There is no doubt that one of the greatest difficulties encountered in treating psychotics is the intensity of the relationship with the therapist which is required. This intensity is apt to bring the therapist's problems to the surface, at times with unexpected violence. (p.463)

Arieti inferred that the onslaught of a psychotic client will evoke difficulties already existent in the therapist, while other authors believed that the client's psychosis itself produces the difficulty.

Edith Weigert (1954) described the difficulty as follows:

> Obstacles in the treatment of psychoses arise rather in the limitations of counter-transference. It is more difficult to identify with the psychotic, to accompany him on the regressive descent into the panic, despair, and loneliness of a psychosis. The analyst has to assess his stamina of endurance. He may become inflicted by the patient's deep discouragement and lose the vision of and the faith in the patient's potentialities for recovery...Is the doubt in the patient's curability a realistic assessment or a prejudice of the analyst, a defense against the anxieties mobilized by the patient's despair?" (p.244)

Margaret Little (1951, 1960) believed that intense countertransference reactions are an outgrowth of the psychotic's behavior and dynamics, not the therapist's conflicts.

> ...there is perhaps a tendency to identify particularly with the patient's id in psychotic cases generally; in fact it would sometimes be difficult to find the ego to identify with! (1951, p. 36)

In this area, as in every area of countertransference, there is strong disagreement. What some authors describe as countertransference difficulties, meaning difficulties within the therapist that need resolution, others attribute to the nature of the problem the patient presents. The difficulties do not rest with the therapist but are inherent to the client's material. This thinking removes the onus from the therapist. It permits one to think non-judgmentally and more openly about the significance of the countertransference reactions. If they are not derived from the therapist's unconscious conflicts, then perhaps the way in which they are evoked can serve as

data about the client's dynamics. For example, a colleague has said that he learned that the hairs on the back of his neck stand up when he is interviewing a psychotic or severely borderline client.

Yet another issue--how to handle countertransference reactions--has engendered as much dissent as any other issue regarding the phenomenon. The basic disagreement centers around whether the therapist should or should not reveal countertransference reactions. The proponents primarily refer to their work with more severely disturbed clients, and believe that it is important to reveal in order to maintain a sense of reality for the client, who has difficulty sorting out reality anyway. Not revealing, in this instance, can intensify the client's confusion. The opponents believe that revelation is an indulgence, and places too great a burden on the client. For them, revelation shifts the focus of the therapeutic work and diffuses it.

The preponderant thinking among the authors is that it is never appropriate to share or reveal countertransference responses. The most notable exceptions were Ferenczi (1919), Gitelson (1953), Little (1951, 1957), Fleiss (1953) and Searles (1965). Each of them recommended revealing countertransference behavior and sources to the client when appropriate for the purpose of strengthening the client's reality-testing function.

ATTITUDE TOWARD COUNTERTRANSFERENCE AS A PHENOMENON

Virtually every writer on the issue had an attitude towards countertransference--and often, a judgmental one. The simple fact that each author had an attitude is indicative of how emotionally

laden the issue is. After all, no one had an attitude toward transference.

The attitudes towards countertransference range from acceptance to rejection, from seeing its manifestations as useful to damning them as harmful, from advocating revelation of countertransference feelings to advocating suppression and analysis for the therapist.

Don Jackson's (1956) attitude towards countertransference was accepting. He described a polarity between the classical and modernist views and, in effect, politicized the two positions:

> I think the extreme right position would be held by those analysts who feel countertransference is a rather specific reaction on the therapist's part to unconscious aspects of therapy by becoming aware of the conflict and suppressing any manifestations on his part that tend to erupt into action. The extreme left position which is the one I hold, states that countertransference is a too limited concept that does not do justice to the fact that the whole way of life of the therapist is very much in the room. This broader view of countertransference is especially pertinent...because the therapist's personality may be of greater import and his nontherapeutic reactions of greater frequency in psychotherapy than psychoanalysis. (pp.235-236)

It is interesting that countertransference phenomena are understood as a detriment by those who see it as revealing of the therapist's problems and as an aid by those who work with the severely disturbed, because the intensity of the therapist's feelings are believed to be induced by the client's demands and projections, and thus often have nothing to do with the therapist's neurosis.

Throughout its history, countertransference has been seen by some authors as an enhancement of therapy--the sublimated libido which

fuels the therapist's investment in the arduous task of therapy. More recently, the diagnostic potentialities of countertransference have become valued.

The field of social casework has always placed a great deal of emphasis on countertransference as one part of the therapeutic interaction, although the term was never used. The concept was explored under the umbrella of the social work precept called "conscious use of self." Yet surprisingly, no social work theoretician related the concept to that of countertransference. Moreover, no definition of that precept has been found within the social work literature.

Florence Hollis (1964), however, used the term countertransference in her discussion of the worker's role in the casework situation:

> The worker is also sometimes unrealistic in his reactions to the client. He may identify the client with an early or later figure in his life, or may bring into the treatment relationship distorted ways of relating to people that are part of his own personality...The term 'countertransference' is rather broadly used to cover not only these unrealistic reactions of the worker but also realistic responses ...that are 'countertherapeutic'. (pp. 154-155)

Not all social work theoreticians had so negative a view. Gordon Hamilton (1947) identified countertransference as the factor involved in a social worker's irrational like or dislike for a client. Some, like Perlman, said nothing. Here and there, articles were published in social work journals regarding difficult treatment populations (Lieberman and Gottesfeld, 1973). Others wrote at

length of transference (Sterba, Lyndon and Katz, 1948; Levey, 1949) without referring to countertransference, except to admonish the clinician to be accepting, understanding and self-examining. In short, there has been a total lack of useful literature related to the idea of the inevitability or usefulness of countertransference phenomena in social work.

SUMMARY

In summary, the concept of countertransference has been discussed in the psychoanalytic literature for almost 70 years. In the beginning it was rarely noted, and then only peripherally. Later, it became more widely recognized, but was viewed as an undesirable phenomenon to be countered, mastered, and controlled. Only during the last two to three decades have authors recognized countertransference non-judgmentally, and as a natural component of the therapeutic dyad. A few recent writers have even recognized the potential utility of countertransference as a diagnostic tool, an aspect emphasized in this project.

CHAPTER 4

THEORETICAL BASE: HEINRICH RACKER'S THEORY OF COUNTERTRANSFERENCE

In order to establish the theoretical framework for the integrative chapter, this chapter focuses on the countertransference theories of Heinrich Racker.

RACKER, THE MAN

Heinrich Racker was an analyst whose professional years were spent in Argentina. He was born into a Jewish family in Poland in 1910. His family fled Poland, for Vienna, at the outset of World War I. Racker entered the Faculty of Medicine in Vienna and began his training analysis. However, the onset of World War II forced his exile. He reached Buenos Aires in 1939, and resumed his training analysis. Becoming an associate member of the Argentine Psychoanalytic Association in 1947, he was elected to full membership in 1950 and became a training analyst in 1951.

Racker's major published work is Transference and Countertransference, published in 1968, seven years after Racker's death in 1961. It comprises papers read to various symposia and meetings during the years 1948 to 1958.

RACKER'S THEORIES

Racker's conceptualization of countertransference grew out of his belief that the countertransference is an integral part of the transference relationship.

> "...At the same time it was clear that the scientific silence which reigned to such a high degree with respect to countertransference phenomena and problems, constituted a serious obstacle for the perception and

> understanding of the transference. For the countertransference is the living response to the transference, and if the former is silenced, the latter cannot reach the fullness of life and knowledge." (1968, p.3)

His conceptualization of countertransference enables the therapist to distinguish a number of interactive and intrapsychic processes that are subsumed under this unbrella-like term. Racker (1968) suggested using the term countertransference generically and broadly, as an analogy to transference.

> "One frequently uses the term transference for the totality of the psychological attitude of the analysand towards the analyst. We know, to be sure, that real external qualities of the analytic situation in general and of the analyst in particular have an important influence on the relationship of the analysand with the analyst, but we also know that all these present factors are experienced according to the past and the fantasy - according that is to say, to a transference predisposition. As determinants of the transference neurosis and, in general, of the psychological situation of the analysand towards the analyst, we have both the transference predisposition and the present real and especially analytic experiences, the transference in its diverse expressions being the result of these two factors.
>
> "Analogously, in the analyst there are the countertransference predispositions and the present real, and especially analytic, experiences; and the countertransference is the result...Where it is necessary for greater clarity one might speak of 'total countertransference' and then differentiate and separate within it one aspect or another." (p.133)

Racker did differentiate and separate aspects. These will be discussed later in this chapter.

Further, he plumbed the depths of the countertransference experience. He explored its meaning in client-therapist transactions and formulated

interpretations based on the understanding that developed. He identified a complex of normal predispositions shared by therapists and said that any of them could, under certain conditions, find themselves in the emotional position of a child vis-a-vis a client-parent. This complex was termed the countertransference neurosis and was understood as being as natural and normal a phenomenon in the therapist as is the transference neurosis in the client.

> "Transference becomes a 'subject,'...mainly when it becomes resistance, when because of resistance, it has become sexual or negative. Analogously, sublimated positive countertransference is the main and indispensable motive force in the analyst's work (disposing him to the continued concordant identification), and countertransference also becomes a technical problem or subject mainly when it becomes sexual or negative. And this occurs (to an intense degree) principally as a resistance - in this case, the analyst's - that is to say, as counter resistance." (1968, p. 136-137)

Racker rejected the classical position that any strong emotion in the therapist, in response to a client, is an aberration and signifies pathology within the therapist. He rejected also, the classical concept that the therapist's normal ego state should be hovering, contemplative, and neutral. Instead, his thesis was that the therapist's emotional state is at all times determined by the client, and is in effect the client's creation. The client influences the therapist's feelings to a degree and in ways not previously appreciated. Even when the therapist seems detached, close examination of the total action usually reveals that the detachment is a defensive maneuver, responsive to something the client is doing. For instance, the therapist's detachment might be a withdrawal from a client who is emotionally flat - who deprives the

therapist of affective stimuli and a human relationship. Racker went on to say that the therapist's emotional state can alert the therapist in a general way towards what is going on, however it cannot give precise information about the client's inner state. He drew an analogy to our sense of smell. Smell informs us of the presence in our environment of a certain material. We must use other sensory means to locate it. So, with countertransference responses. Racker recognized that the therapist is both the interpreter and the object of the client's unconscious processes. As interpreter, the therapist's countertransference...

> "may help, distort, or hinder the perception of the unconscious process. Or again, the perception may be correct but the precept may provoke neurotic reactions which impair his interpretative capacity. As regards the latter - the analyst as object - the countertransference affects his manner and his behaviour which in turn influence the image the analysand forms of him." (1968, p.105)

Racker was cautious in his recommendations concerning what the therapist does with countertransference reactions.

His model described the use of such reactions for diagnosis, rather than solely for self-revelation. His view was that the therapist uses the countertransference as an aid in formulating appropriate interpretations. He (1968) did not rule out the direct communication of countertransference reactions but advised that: "We need extensive and detailed study of the inherent problems of communication of countertransference." (p.173)

Racker divides the totality of countertransference into component aspects. For this study, these aspects have been divided into two categories: 1) that which is transferred, i.e., that part of relating

that originated in an earlier time, and 2) that which involves differing processes of identification.

ASPECT 1

The first of these aspects consists of that which is transferred in countertransference. That is to say, it consists of that piece of the interrelationship originating in the early life of the therapist, and especially includes infantile and primitive parts within the total countertransference. As was earlier indicated, Racker believed that a therapist can never enter the session as a blank screen. Rather, both pathological and non-pathological memories are transferred onto the therapeutic dyad. Racker (1968) again uses the transference analogy to distinguish the pathological from the non-pathological:

> "Just as the whole of the patient's images, feelings and impulses towards the analyst, insofar as they are determined by the past, is called 'transference' and its pathological expression 'transference neurosis', in the same way the whole of the analyst's images, feelings and impulses towards the patient, insofar as they are determined by the past, are called 'counter-transference' and its pathological expression may be called 'countertransference neurosis." (p.106)

In this study, the neurotic components of countertransference are viewed as a subcategory of the totality of what is transferred, although Racker viewed them as different but closely related. He (1968) characterized what is neurotic in countertransference as being "unreal anxiety" and "pathological defenses." (p.134) Racker's use of the term "neurotic," was non-judgmental and accepting. He did not believe that the absence of countertransference was possible, indeed he (1968) believed that even pathological, neurotic countertransference

reactions were always just around the corner.

> "although the neurotic reactions of counter-transference may be sporadic, the predisposition to them is continuous." (p.111)

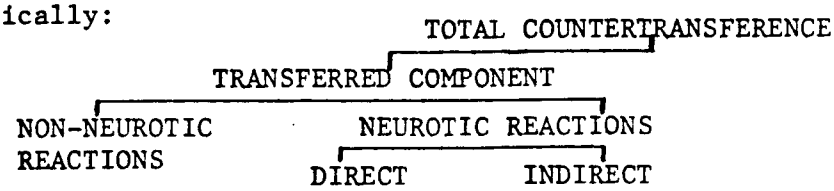
> "The transference is always present and always reveals its presence. Likewise counter-transference is always present and always reveals its presence, although, as in the case of transference, its manifestations are sometimes hard to perceive and interpret." (p.106)

The neurotic components of countertransference were divided into two forms: the direct and the indirect.

The direct form results from the therapist's conscious or unconscious perception of the client as the object of the neurotic transference. That is to say, the client becomes the object of the therapist's neurotic transference which is an idea similar to the traditional view of countertransference.

The indirect form of neurotic countertransference differs from the direct in that the therapist's internal objects are projected onto something or someone outside the therapeutic dyad; i.e., society, the profession, a supervisor, a referral source, etc. The client is no longer the directly designated source of acceptance or rejection, but rather, is the means of obtaining such a response from another real or imagined individual. The differentiation seems labored, yet is invaluable when applied clinically.

This segment of the total countertransference reaction can be depicted schematically:



ASPECT 2

The second aspect of total countertransference is the one more fully developed by Racker. He, as had Helene Deutsch (1926), among others, recognized that certain processes of identification took place within the therapist in the therapeutic interchange, and that these identifications influence the therapist's countertransference feelings. "As for...the influence of countertransference upon the analyst's understanding, we must remember, above all, what processes this understanding is based on." (p.124) As he identified these processes, Racker returned to Deutsch's formulation, borrowed her terminology, build upon her foundation and developed his conceptual model. That model, according to Kenneth Frank (1977) gave each therapist...

> "permission to experience fully, and to use constructively, his subjective reactions to his patient. They are, in effect, legitimized, thus releasing fuller psychotherapeutic potentiality. One can see why Racker has termed countertransference the 'Cinderella of psychoanalysis'." (p.5)

Racker recognized two kinds of identifications--concordant and complementary.

Concordant identifications occur when the therapist's feelings are in accord with and parallel to the client's. This condition is similar to that described by Weigert (1951) as 'empathic identification.'

For example, the therapist who feels pain for and with a client relating a pain-filled memory, experiences concordant identification. Racker (1968) describes the phenomenon as follows:

> "The concordant identification is based on introjection and projection, or in other terms,

> on the resonance of the exterior in the interior, or recognition of what belongs to another as one's own ('This part of you is I') and on the equation of what is one's own with what belongs to another ('This part of me is you')." (p.134)

Such identifications occur, according to Racker, when the therapist identifies

> "his ego with the patient's ego or, to put it more clearly although with a certain terminological inexactitude, by identifying each part of his personality with the corresponding psychological part in the patient - his id with the patient's id, his ego with the ego, his superego with the superego, accepting these identifications in his consciousness." (p.134)

Racker understands concordant identifications as the basis of the therapist's empathy, and carefully builds a case for viewing empathy as the result of sublimated positive countertransference. In summary, concordant identification is Racker's term for what is usually thought of as empathic identification. It is characterized by an identification with the client's thoughts and feelings, as if the therapist's feelings run alongside the client's. Concordant identifications can give the therapist information about the client's self-experience.

Complementary identifications occur when the therapist's feelings complement or form a counterpart to the client's feelings. They occur in sessions when the client recreates an earlier relationship and does that so effectively that the therapist feels as did the original object. It is as if the client had projected his image of a childhood figure onto the therapist with such intensity that the therapist accepts the projection and feels accordingly. The therapist now no longer understands the client from the inside, i.e., according to the

client's feelings, but instead seems to be outside the client, reacting in ways similar to the ways in which the original object reacted. For example, a needy and hungry client can become so whiny and clingy that the therapist may respond as did the client's parent. The therapist may feel empathic with the client-rejecting parent rather than with the ignored child. In this instance, the therapist's response complements the client's behavior. The client has, in effect, recreated the original painful situation.

Racker believed that such identifications were inherent in the treatment relationship. For example, there can be no concept of mother without the complementary concept of child. Racker (1968) believed that complementary identifications were

> "...producted by the fact that the patient treats the analyst as an internal (projected) object, and in consequence the analyst feels treated as such; that is, he identifies himself with this object..." (p.134-135)

Because the therapist feels treated as, and partially identifies with an internal object of the client, psychological processes in the therapist result in the client's being overvalued, becoming an internal object of the therapist. Winnicott's (1949) third definition of countertransference

> "the analyst's love and hate in reaction to the actual personality and behavior of the patient, based on objective observation..." (p.69)

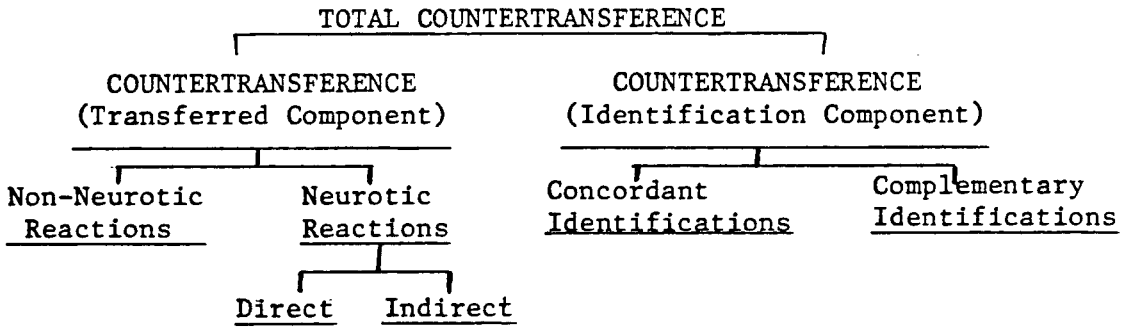
describes a complementary identification. Another example can be found in Ferenczi's (1930) concern for being a "good object."

In any one session, the therapist moves back and forth from one kind of identification to the other. At one point, the therapist may

feel in accord, or empathic with the subjective feelings the client is communicating. At other moments, the therapist may respond as if he or she were indeed the object of the client's projections.

In summary, identifications may be understood more as one of the therapist's reactions to the client's behavior than as a true identification. Such identifications (or reactions) give the therapist information about significant others in the client's life - usually early ones - as they were experienced by the client. Thus, in the earlier example of the whiny client, the therapist can learn something of how that client experienced his parent in early childhood.

The schematic representation of total countertransference can now be expanded and depicted as follows:



Racker further refined this conceptual model by examining and classifying the therapist's use (or misuse) of countertransference responses. He distinguished between countertransference thoughts and countertransference positions. According to Racker (1968):

> "The outstanding difference between the two lies in the degree to which the ego is involved in the experience. In one case, the reactions are experienced as thoughts, free associations, or fantasies, with no great emotional intensity and frequency, as if they were somewhat foreign to the ego. In the other case, the analyst's ego is involved in the countertransference experience and the experience is felt by him

> with great intensity and as true reality, and there is danger of his 'drowning' in this experience," (p.144)

The example Racker cited as a familiar one: he described the anger the therapist experiences as a result of the client's resistance and designated it a countertransference position.

As Racker's comments indicate, it is not difficult to distinguish (at least theoretically) between countertransference thoughts and positions. Countertransference thoughts are not experienced with any appreciable anxiety or discomfort. The therapist's ego involvement is minimal. An example of a concordant countertransference thought follows:

> Rodney was describing his efforts to take care of a close friend. I kept imagining a kitten, shared the fantasy with Rodney, explaining that I did not understand what my fantasy was about. Rodney was quick to respond: not a kitten, but a wounded bird. We explored the way in which he projected the wounded bird within himself onto others so as to experience, vicariously, the nurturing that he longed for.

In this instance, the therapist's experience was not intense, rather one of being able to free associate, and use that association to gain fuller insight into the client's processes. The following example illustrates a complementary countertransference position.

> Randy expresses her helplessness and suffering repeatedly, intensely and in such a fashion that I am certain that she is demanding that I take care of her. Sometimes I am certain that she is demanding that I adopt her. I experience anger. At times my anger is so intense that I want to push her away. I am sure that I am identifying with her internal object, and that is the source of my anger at her demands.

Another group of therapists sees the countertransference as a source of insight into the therapeutic process, most notably Fromm-Reichmann (1950), Hora (1956), Benedek (1953), Freebury (1978), Sandler (1970, 1976) and Ross (1962). Still others see countertransference as a key to the client's unconscious. This takes us back to Freud (1912), who believed it possible for one unconscious to know the other--a meeting of the unconscious, as it were. Maltsberger and Buie (1974) commented on this:

> When countertransference is fully conscious it can stimulate the introspection in the therapist, can usually be controlled, and can direct his attention to details of his patient's behavior the meaning of which might otherwise remain obscure. Otherwise, when unconscious, countertransference may generate well rationalized but destructive acting out by the therapist. (p.625)

Unfortunately, the authors do not let the readers know how to make the countertransference fully conscious. Perhaps it is possible to utilize Mabel Cohen's (1952) series of signals through which the therapist can become aware of such difficulties. Although her list is quite long, it includes such clues as an inability to identify with the client, overemotional responses, unreasonable like or dislike for the client, drowsiness, arguing, defensiveness, etc. These responses, taken as signals, can clue the therapist to the existence of a countertransference reaction although it may be specifically identified.

Rosenfeld (1964) discusses the use of the therapist's counter-transference in work with psychotic clients:

> In my opinion the unconscious intuitive understanding by the psychoanalyst of what a patient is conveying to him is an essential factor in

> all analyses, and depends on the analyst's capacity to use his countertransference as a kind of sensitive 'receiving' set. In treating schizophrenics who have such great verbal difficulties, the unconscious intuitive understanding of the analyst, through the countertransference is even more important, for it helps him to determine what it is that really matters at the moment. But the analyst should also be able to formulate consciously what he has unconsciously recognized and to convey it to the patient in a form that he can understand. This after all is the essence of all psychoanalysis... (p.76)

Although considerable discussion in this dissertation has already focused on the negative aspects of countertransference, some attention needs to be paid to the body of literature written specifically about the countertransference difficulties encountered when working with severely disordered individuals. It is commonly recognized that these patients evoke and provoke responses in the therapist that are substantively different from those evoked by more neurotically structured individuals. The issue of the therapist's unresolved libidinal struggles seems not to pertain to this population.

Silvano Arieti (1955) stated this idea succinctly:

> There is no doubt that one of the greatest difficulties encountered in treating psychotics is the intensity of the relationship with the therapist which is required. This intensity is apt to bring the therapist's problems to the surface, at times with unexpected violence. (p.463)

Arieti inferred that the onslaught of a psychotic client will evoke difficulties already existent in the therapist, while other authors believed that the client's psychosis itself produces the difficulty.

Edith Weigert (1954) described the difficulty as follows:

> Obstacles in the treatment of psychoses arise rather in the limitations of countertransference. It is more difficult to identify with the psychotic, to accompany him on the regressive descent into the panic, despair, and loneliness of a psychosis. The analyst has to assess his stamina of endurance. He may become inflicted by the patient's deep discouragement and lose the vision of and the faith in the patient's potentialities for recovery...Is the doubt in the patient's curability a realistic assessment or a prejudice of the analyst, a defense against the anxieties mobilized by the patient's despair?" (p.244)

Margaret Little (1951, 1960) believed that intense countertransference reactions are an outgrowth of the psychotic's behavior and dynamics, not the therapist's conflicts.

> ...there is perhaps a tendency to identify particularly with the patient's id in psychotic cases generally; in fact it would sometimes be difficult to find the ego to identify with! (1951, p. 36)

In this area, as in every area of countertransference, there is strong disagreement. What some authors describe as countertransference difficulties, meaning difficulties within the therapist that need resolution, others attribute to the nature of the problem the patient presents. The difficulties do not rest with the therapist but are inherent to the client's material. This thinking removes the onus from the therapist. It permits one to think non-judgmentally and more openly about the significance of the countertransference reactions. If they are not derived from the therapist's unconscious conflicts, then perhaps the way in which they are evoked can serve as

data about the client's dynamics. For example, a colleague has said that he learned that the hairs on the back of his neck stand up when he is interviewing a psychotic or severely borderline client.

Yet another issue--how to handle countertransference reactions--has engendered as much dissent as any other issue regarding the phenomenon. The basic disagreement centers around whether the therapist should or should not reveal countertransference reactions. The proponents primarily refer to their work with more severely disturbed clients, and believe that it is important to reveal in order to maintain a sense of reality for the client, who has difficulty sorting out reality anyway. Not revealing, in this instance, can intensify the client's confusion. The opponents believe that revelation is an indulgence, and places too great a burden on the client. For them, revelation shifts the focus of the therapeutic work and diffuses it.

The preponderant thinking among the authors is that it is never appropriate to share or reveal countertransference responses. The most notable exceptions were Ferenczi (1919), Gitelson (1953), Little (1951, 1957), Fleiss (1953) and Searles (1965). Each of them recommended revealing countertransference behavior and sources to the client when appropriate for the purpose of strengthening the client's reality-testing function.

ATTITUDE TOWARD COUNTERTRANSFERENCE AS A PHENOMENON

Virtually every writer on the issue had an attitude towards countertransference--and often, a judgmental one. The simple fact that each author had an attitude is indicative of how emotionally

laden the issue is. After all, no one had an attitude toward transference.

The attitudes towards countertransference range from acceptance to rejection, from seeing its manifestations as useful to damning them as harmful, from advocating revelation of countertransference feelings to advocating suppression and analysis for the therapist.

Don Jackson's (1956) attitude towards countertransference was accepting. He described a polarity between the classical and modernist views and, in effect, politicized the two positions:

> I think the extreme right position would be held by those analysts who feel countertransference is a rather specific reaction on the therapist's part to unconscious aspects of therapy by becoming aware of the conflict and suppressing any manifestations on his part that tend to erupt into action. The extreme left position which is the one I hold, states that countertransference is a too limited concept that does not do justice to the fact that the whole way of life of the therapist is very much in the room. This broader view of countertransference is especially pertinent...because the therapist's personality may be of greater import and his nontherapeutic reactions of greater frequency in psychotherapy than psychoanalysis. (pp.235-236)

It is interesting that countertransference phenomena are understood as a detriment by those who see it as revealing of the therapist's problems and as an aid by those who work with the severely disturbed, because the intensity of the therapist's feelings are believed to be induced by the client's demands and projections, and thus often have nothing to do with the therapist's neurosis.

Throughout its history, countertransference has been seen by some authors as an enhancement of therapy--the sublimated libido which

fuels the therapist's investment in the arduous task of therapy. More recently, the diagnostic potentialities of countertransference have become valued.

The field of social casework has always placed a great deal of emphasis on countertransference as one part of the therapeutic interaction, although the term was never used. The concept was explored under the umbrella of the social work precept called "conscious use of self." Yet surprisingly, no social work theoretician related the concept to that of countertransference. Moreover, no definition of that precept has been found within the social work literature.

Florence Hollis (1964), however, used the term countertransference in her discussion of the worker's role in the casework situation:

> The worker is also sometimes unrealistic in his reactions to the client. He may identify the client with an early or later figure in his life, or may bring into the treatment relationship distorted ways of relating to people that are part of his own personality...The term 'counter-transference' is rather broadly used to cover not only these unrealistic reactions of the worker but also realistic responses ...that are 'countertherapeutic'. (pp. 154-155)

Not all social work theoreticians had so negative a view. Gordon Hamilton (1947) identified countertransference as the factor involved in a social worker's irrational like or dislike for a client. Some, like Perlman, said nothing. Here and there, articles were published in social work journals regarding difficult treatment populations (Lieberman and Gottesfeld, 1973). Others wrote at

length of transference (Sterba, Lyndon and Katz, 1948; Levey, 1949) without referring to countertransference, except to admonish the clinician to be accepting, understanding and self-examining. In short, there has been a total lack of useful literature related to the idea of the inevitability or usefulness of countertransference phenomena in social work.

SUMMARY

In summary, the concept of countertransference has been discussed in the psychoanalytic literature for almost 70 years. In the beginning it was rarely noted, and then only peripherally. Later, it became more widely recognized, but was viewed as an undesirable phenomenon to be countered, mastered, and controlled. Only during the last two to three decades have authors recognized countertransference non-judgmentally, and as a natural component of the therapeutic dyad. A few recent writers have even recognized the potential utility of countertransference as a diagnostic tool, an aspect emphasized in this project.

CHAPTER 4

THEORETICAL BASE: HEINRICH RACKER'S THEORY OF COUNTERTRANSFERENCE

In order to establish the theoretical framework for the integrative chapter, this chapter focuses on the countertransference theories of Heinrich Racker.

RACKER, THE MAN

Heinrich Racker was an analyst whose professional years were spent in Argentina. He was born into a Jewish family in Poland in 1910. His family fled Poland, for Vienna, at the outset of World War I. Racker entered the Faculty of Medicine in Vienna and began his training analysis. However, the onset of World War II forced his exile. He reached Buenos Aires in 1939, and resumed his training analysis. Becoming an associate member of the Argentine Psychoanalytic Association in 1947, he was elected to full membership in 1950 and became a training analyst in 1951.

Racker's major published work is Transference and Countertransference, published in 1968, seven years after Racker's death in 1961. It comprises papers read to various symposia and meetings during the years 1948 to 1958.

RACKER'S THEORIES

Racker's conceptualization of countertransference grew out of his belief that the countertransference is an integral part of the transference relationship.

> "...At the same time it was clear that the scientific silence which reigned to such a high degree with respect to countertransference phenomena and problems, constituted a serious obstacle for the perception and

> understanding of the transference. For the countertransference is the living response to the transference, and if the former is silenced, the latter cannot reach the fullness of life and knowledge."(1968, p.3)

His conceptualization of countertransference enables the therapist to distinguish a number of interactive and intrapsychic processes that are subsumed under this unbrella-like term. Racker (1968) suggested using the term countertransference generically and broadly, as an analogy to transference.

> "One frequently uses the term transference for the totality of the psychological attitude of the analysand towards the analyst. We know, to be sure, that real external qualities of the analytic situation in general and of the analyst in particular have an important influence on the relationship of the analysand with the analyst, but we also know that all these present factors are experienced according to the past and the fantasy - according that is to say, to a transference predisposition. As determinants of the transference neurosis and, in general, of the psychological situation of the analysand towards the analyst, we have both the transference predisposition and the present real and especially analytic experiences, the transference in its diverse expressions being the result of these two factors.
>
> "Analogously, in the analyst there are the countertransference predispositions and the present real, and especially analytic, experiences; and the countertransference is the result...Where it is necessary for greater clarity one might speak of 'total countertransference' and then differentiate and separate within it one aspect or another." (p.133)

Racker did differentiate and separate aspects. These will be discussed later in this chapter.

Further, he plumbed the depths of the countertransference experience. He explored its meaning in client-therapist transactions and formulated

interpretations based on the understanding that developed. He identified a complex of normal predispositions shared by therapists and said that any of them could, under certain conditions, find themselves in the emotional position of a child vis-a-vis a client-parent. This complex was termed the countertransference neurosis and was understood as being as natural and normal a phenomenon in the therapist as is the transference neurosis in the client.

> "Transference becomes a 'subject,'...mainly when it becomes resistance, when because of resistance, it has become sexual or negative. Analogously, sublimated positive countertransference is the main and indispensable motive force in the analyst's work (disposing him to the continued concordant identification), and countertransference also becomes a technical problem or subject mainly when it becomes sexual or negative. And this occurs (to an intense degree) principally as a resistance - in this case, the analyst's - that is to say, as counterresistance." (1968, p. 136-137)

Racker rejected the classical position that any strong emotion in the therapist, in response to a client, is an aberration and signifies pathology within the therapist. He rejected also, the classical concept that the therapist's normal ego state should be hovering, contemplative, and neutral. Instead, his thesis was that the therapist's emotional state is at all times determined by the client, and is in effect the client's creation. The client influences the therapist's feelings to a degree and in ways not previously appreciated. Even when the therapist seems detached, close examination of the total action usually reveals that the detachment is a defensive maneuver, responsive to something the client is doing. For instance, the therapist's detachment might be a withdrawal from a client who is emotionally flat - who deprives the

therapist of affective stimuli and a human relationship. Racker went on to say that the therapist's emotional state can alert the therapist in a general way towards what is going on, however it cannot give precise information about the client's inner state. He drew an analogy to our sense of smell. Smell informs us of the presence in our environment of a certain material. We must use other sensory means to locate it. So, with countertransference responses. Racker recognized that the therapist is both the interpreter and the object of the client's unconscious processes. As interpreter, the therapist's countertransference...

> "may help, distort, or hinder the perception of the unconscious process. Or again, the perception may be correct but the precept may provoke neurotic reactions which impair his interpretative capacity. As regards the latter - the analyst as object - the countertransference affects his manner and his behaviour which in turn influence the image the analysand forms of him." (1968, p.105)

Racker was cautious in his recommendations concerning what the therapist does with countertransference reactions.

His model described the use of such reactions for diagnosis, rather than solely for self-revelation. His view was that the therapist uses the countertransference as an aid in formulating appropriate interpretations. He (1968) did not rule out the direct communication of countertransference reactions but advised that: "We need extensive and detailed study of the inherent problems of communication of countertransference." (p.173)

Racker divides the totality of countertransference into component aspects. For this study, these aspects have been divided into two categories: 1) that which is transferred, i.e., that part of relating

that originated in an earlier time, and 2) that which involves differing processes of identification.

ASPECT 1

The first of these aspects consists of that which is transferred in countertransference. That is to say, it consists of that piece of the interrelationship originating in the early life of the therapist, and especially includes infantile and primitive parts within the total countertransference. As was earlier indicated, Racker believed that a therapist can never enter the session as a blank screen. Rather, both pathological and non-pathological memories are transferred onto the therapeutic dyad. Racker (1968) again uses the transference analogy to distinguish the pathological from the non-pathological:

> "Just as the whole of the patient's images, feelings and impulses towards the analyst, insofar as they are determined by the past, is called 'transference' and its pathological expression 'transference neurosis', in the same way the whole of the analyst's images, feelings and impulses towards the patient, insofar as they are determined by the past, are called 'counter-transference' and its pathological expression may be called 'countertransference neurosis." (p.106)

In this study, the neurotic components of countertransference are viewed as a subcategory of the totality of what is transferred, although Racker viewed them as different but closely related. He (1968) characterized what is neurotic in countertransference as being "unreal anxiety" and "pathological defenses." (p.134) Racker's use of the term "neurotic," was non-judgmental and accepting. He did not believe that the absence of countertransference was possible, indeed he (1968) believed that even pathological, neurotic countertransference

reactions were always just around the corner.

> "although the neurotic reactions of counter-transference may be sporadic, the predisposition to them is continuous." (p.111)

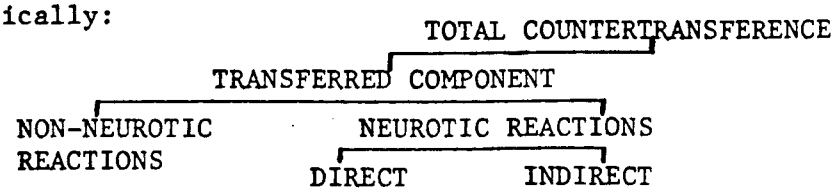
> "The transference is always present and always reveals its presence. Likewise counter-transference is always present and always reveals its presence, although, as in the case of transference, its manifestations are sometimes hard to perceive and interpret." (p.106)

The neurotic components of countertransference were divided into two forms: the direct and the indirect.

The direct form results from the therapist's conscious or unconscious perception of the client as the object of the neurotic transference. That is to say, the client becomes the object of the therapist's neurotic transference which is an idea similar to the traditional view of countertransference.

The indirect form of neurotic countertransference differs from the direct in that the therapist's internal objects are projected onto something or someone outside the therapeutic dyad; i.e., society, the profession, a supervisor, a referral source, etc. The client is no longer the directly designated source of acceptance or rejection, but rather, is the means of obtaining such a response from another real or imagined individual. The differentiation seems labored, yet is invaluable when applied clinically.

This segment of the total countertransference reaction can be depicted schematically:



ASPECT 2

The second aspect of total countertransference is the one more fully developed by Racker. He, as had Helene Deutsch (1926), among others, recognized that certain processes of identification took place within the therapist in the therapeutic interchange, and that these identifications influence the therapist's countertransference feelings. "As for...the influence of countertransference upon the analyst's understanding, we must remember, above all, what processes this understanding is based on." (p.124) As he identified these processes, Racker returned to Deutsch's formulation, borrowed her terminology, build upon her foundation and developed his conceptual model. That model, according to Kenneth Frank (1977) gave each therapist...

> "permission to experience fully, and to use constructively, his subjective reactions to his patient. They are, in effect, legitimized, thus releasing fuller psychotherapeutic potentiality. One can see why Racker has termed countertransference the 'Cinderella of psychoanalysis'." (p.5)

Racker recognized two kinds of identifications--concordant and complementary.

Concordant identifications occur when the therapist's feelings are in accord with and parallel to the client's. This condition is similar to that described by Weigert (1951) as 'empathic identification.'

For example, the therapist who feels pain for and with a client relating a pain-filled memory, experiences concordant identification. Racker (1968) describes the phenomenon as follows:

> "The concordant identification is based on introjection and projection, or in other terms,

> on the resonance of the exterior in the interior, or recognition of what belongs to another as one's own ('This part of you is I') and on the equation of what is one's own with what belongs to another ('This part of me is you')." (p.134)

Such identifications occur, according to Racker, when the therapist identifies

> "his ego with the patient's ego or, to put it more clearly although with a certain terminological inexactitude, by identifying each part of his personality with the corresponding psychological part in the patient - his id with the patient's id, his ego with the ego, his superego with the superego, accepting these identifications in his consciousness." (p.134)

Racker understands concordant identifications as the basis of the therapist's empathy, and carefully builds a case for viewing empathy as the result of sublimated positive countertransference. In summary, concordant identification is Racker's term for what is usually thought of as empathic identification. It is characterized by an identification with the client's thoughts and feelings, as if the therapist's feelings run alongside the client's. Concordant identifications can give the therapist information about the client's self-experience.

Complementary identifications occur when the therapist's feelings complement or form a counterpart to the client's feelings. They occur in sessions when the client recreates an earlier relationship and does that so effectively that the therapist feels as did the original object. It is as if the client had projected his image of a childhood figure onto the therapist with such intensity that the therapist accepts the projection and feels accordingly. The therapist now no longer understands the client from the inside, i.e., according to the

client's feelings, but instead seems to be outside the client, reacting in ways similar to the ways in which the original object reacted. For example, a needy and hungry client can become so whiny and clingy that the therapist may respond as did the client's parent. The therapist may feel empathic with the client-rejecting parent rather than with the ignored child. In this instance, the therapist's response complements the client's behavior. The client has, in effect, recreated the original painful situation.

Racker believed that such identifications were inherent in the treatment relationship. For example, there can be no concept of mother without the complementary concept of child. Racker (1968) believed that complementary identifications were

> "...producted by the fact that the patient treats the analyst as an internal (projected) object, and in consequence the analyst feels treated as such; that is, he identifies himself with this object..." (p.134-135)

Because the therapist feels treated as, and partially identifies with an internal object of the client, psychological processes in the therapist result in the client's being overvalued, becoming an internal object of the therapist. Winnicott's (1949) third definition of countertransference

> "the analyst's love and hate in reaction to the actual personality and behavior of the patient, based on objective observation..." (p.69)

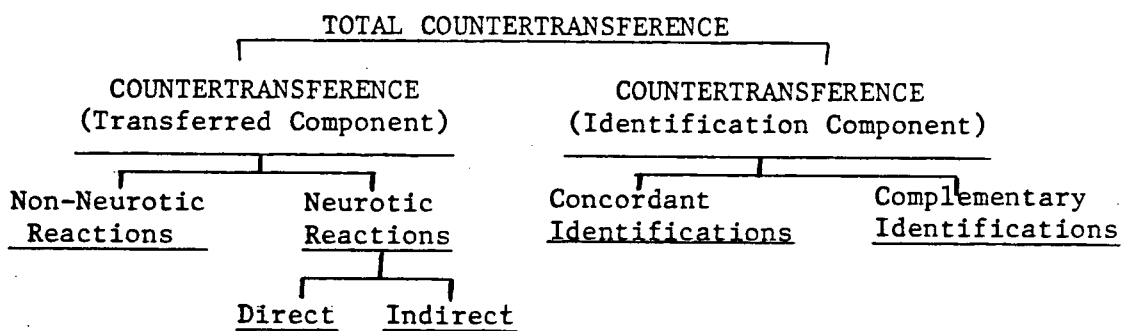
describes a complementary identification. Another example can be found in Ferenczi's (1930) concern for being a "good object."

In any one session, the therapist moves back and forth from one kind of identification to the other. At one point, the therapist may

feel in accord, or empathic with the subjective feelings the client is communicating. At other moments, the therapist may respond as if he or she were indeed the object of the client's projections.

In summary, identifications may be understood more as one of the therapist's reactions to the client's behavior than as a true identification. Such identifications (or reactions) give the therapist information about significant others in the client's life - usually early ones - as they were experienced by the client. Thus, in the earlier example of the whiny client, the therapist can learn something of how that client experienced his parent in early childhood.

The schematic representation of total countertransference can now be expanded and depicted as follows:



Racker further refined this conceptual model by examining and classifying the therapist's use (or misuse) of countertransference responses. He distinguished between countertransference thoughts and countertransference positions. According to Racker (1968):

> "The outstanding difference between the two lies in the degree to which the ego is involved in the experience. In one case, the reactions are experienced as thoughts, free associations, or fantasies, with no great emotional intensity and frequency, as if they were somewhat foreign to the ego. In the other case, the analyst's ego is involved in the countertransference experience and the experience is felt by him

> with great intensity and as true reality, and there is danger of his 'drowning' in this experience," (p.144)

The example Racker cited as a familiar one: he described the anger the therapist experiences as a result of the client's resistance and designated it a countertransference position.

As Racker's comments indicate, it is not difficult to distinguish (at least theoretically) between countertransference thoughts and positions. Countertransference thoughts are not experienced with any appreciable anxiety or discomfort. The therapist's ego involvement is minimal. An example of a concordant countertransference thought follows:

> Rodney was describing his efforts to take care of a close friend. I kept imagining a kitten, shared the fantasy with Rodney, explaining that I did not understand what my fantasy was about. Rodney was quick to respond: not a kitten, but a wounded bird. We explored the way in which he projected the wounded bird within himself onto others so as to experience, vicariously, the nurturing that he longed for.

In this instance, the therapist's experience was not intense, rather one of being able to free associate, and use that association to gain fuller insight into the client's processes. The following example illustrates a complementary countertransference position.

> Randy expresses her helplessness and suffering repeatedly, intensely and in such a fashion that I am certain that she is demanding that I take care of her. Sometimes I am certain that she is demanding that I adopt her. I experience anger. At times my anger is so intense that I want to push her away. I am sure that I am identifying with her internal object, and that is the source of my anger at her demands.

Racker believed that these two kinds of countertransference reactions differ in their intrapsychic origins. Countertransference thoughts occur in a receptive, non-defensive emotional climate. While it may not be in the client's immediate awareness, the thought, feeling, or impulse expressed in the therapist's thought is one to which the client is receptive; it is not a denied or disavowed part of himself. Conversely, the therapist's countertransference positions (which may be experienced with great intensity and even as reality) arise from the client's acting out. The client disowns his impulse, affect, or internal object and projects it onto the therapist. The therapist then unconsciously internalizes the projected object and thereby feels like responding according to the client expectations.

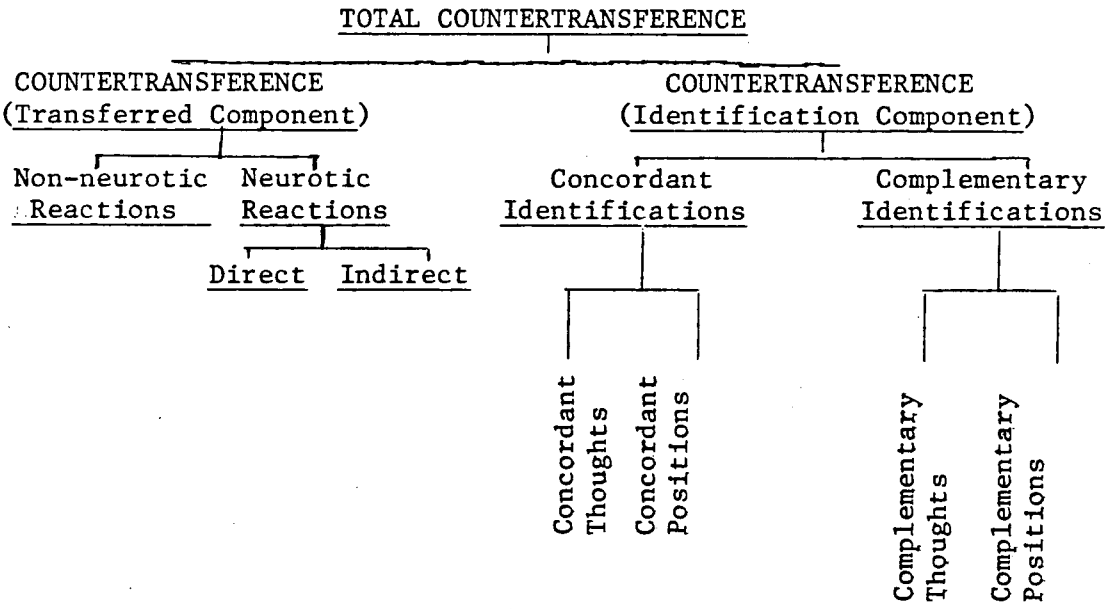
The unique psychological makeup of the therapist is active in determining whether the countertransference reaction will be experienced as a countertransference thought or as a countertransference position. A therapist may respond to some situations by perceiving and watching his or her reactions, to others by acting out those reactions. The type of response that will occur depends on the therapist's neurotic disposition, inclination to anxiety, defense mechanisms and general inclination to repeat (act out) rather than to lift the impulse or feeling to consciousness. Perhaps because he did not work with psychotics or narcissistic personality disorders, Racker was not aware that the inclination to experience countertransference positions instead of countertransference thoughts with particular clients can be important diagnostic information.

Otto Kernberg (1975) recognized this phenomenon:

> "The more intense and premature the therapist's emotional reaction to the patient, the more threatening it becomes to the therapist's neutrality, and the more it has a quickly changing, fluctuating and chaotic nature, the more we can think that the therapist is in the presence of severe regression in the patient." (p.54-55)

This intense emotional reaction can be anticipated, using Racker's model, inasmuch as the client has an impairment of ego boundaries in the area of differentiation between self and nonself. Thus, Racker's conceptualization can be diagnostically useful. This issue will be dealt with in a subsequent chapter.

The total schematic representation of Racker's conceptual model of countertransference can now be depicted as follows:



In summary, this chapter has reviewed Heinrich Racker's theoretical conceptualization of the countertransference phenomenon. According to Racker, countertransference, therefore, is the whole of therapist's images, feelings, and impulses towards the client. In part

they are determined by the therapist's past relations, especially those with significant others, and in part they are determined by the therapist's realistic and neurotic needs. Additionally, countertransference is determined by the therapist's identifications with the client's internal objects and with the client's id, ego, and superego, that is, the client's personality.

The schematic representation of Racker's formulation was developed by this author in the course of elucidating Racker's theory. This review has been written in order to establish the theoretical framework used in this study.

CHAPTER 5

SCHIZOPHRENIA AND THE THEORIES OF HAROLD SEARLES

INTRODUCTION

In order to establish a theoretical framework for this project, this chapter focuses on Searles' theory of schizophrenia. It describes schizophrenia and its etiology, the level of developmental arrest characteristic of this syndrome, the typical intrapsychic structure, and clinical manifestations seen in individuals so afflicted. The latter half of the chapter summarizes Searles' treatment philosophy and examines in detail the treatment phases he describes.

A DESCRIPTION OF SCHIZOPHRENIA

1. Etiology

Any understanding of schizophrenia is inextricably bound to a specific theory of etiology. There are a number of extant theories. Some theorists consider it a regression to lower cognitive levels of functioning (Brown, 1977) or anthropologically earlier stages of human development (Jaynes, 1976). Others view it as a disease of the brain in the medical sense--a disease related to the size of the ventricles (Greenberg, 1979) or to an overabundance of dopamine, a neurotransmitter, in the brain's limbic system (Greenberg, 1978). It has been understood as the reflection of an undetermined genetic fault; one which contributes to a heightened susceptibility to stress (Cancro, 1979). Many view schizophrenia as environmentally determined, i.e., as the outcome of a variety of dystonic experiences--interpersonal,

familial, social and cultural (Lidz, 1965; Wynne, 1958). These considerations reflect the conflict between nature and nurture as causative agents. Bellak (1979) holds a more integrative view. He understands schizophrenia as a term applied to a variety of disorders of different etiologies and varying pathogenic natures, all of which contribute to a common, complex syndrome. Still other investigations debate whether schizophrenia results from a permanent organic deficit or from a defense against a core conflict involving overwhelming affects. Searles (1965) is among those who believe it is an illness which exists in order to function as a defense against overwhelming anxiety.

This author's view somewhat at variance with those described, has developed as the result of long-term, intensive work with a number of schizophrenic clients. This view holds that individuals designated as schizophrenic seem to have inherited a less than normal ego endowment and consequently are particularly vulnerable to stress. Under the best of nurturing environments, this vulnerability may never become manifest. However, in an anxious or covertly hostile family system, i.e., in a stressful environment, the vulnerability can result in schizophrenia.

There is considerable speculation about schizophrenia and wide divergence within the profession regarding its causes. Such wide divergence reflects the still developing state of knowledge about this complex human condition. However, whatever the etiological considerations, we must consider the sociopsychological manifestations called schizophrenia as problems in their own right.

2. Level of Developmental Arrest

What is not speculation is that the adult pathology results in behavior bearing a strong resemblance to infantile emotional behavior. The schizophrenic's rage reactions, belief in personal omnipotence, and inability to perceive reality are very like those of a young child. Much of the schizophrenic's behavior seems to reflect the orientation and difficulties of an infant's early months. Mahler (1975) designated the first few weeks of life as the autistic phase, a time without defined objects. She designated the second to the sixth month of life the symbiotic phase, the preobject phase of development. Her description is apt:

> "From the second month on, dim awareness of the need-satisfying object marks the beginning of the phase of normal symbiosis in which the infant behaves and functions as though he and mother were an omnipotent system. At this time, the quasi-solid stimulus barrier--the autisitic shell which kept external stimuli out--begins to crack," (p.44)

Mahler's description of the autistic shell is reminiscent of the schizophrenic's shell-like withdrawal. Autism or symbiosis: these polarities seem to be the only choices available to the schizophrenic.

Mahler first describes the infant's symbiotic experience as she observed it and then relates to pathology.

> "The essential feature of symbiosis is hallucinatory or delusional somatopsychic <u>omnipotent</u> fusion with the representation of the mother and, in particular, the delusion of a common boundary between two physically separate individuals. This is the mechanism to which the ego regresses in cases of the most severe disturbance of individuation and psychotic disorganization." (p.45)

The schizophrenic individual seems to be one who is psychically arrested at an infantile developmental level--at least as regards the ability to distinguish self from other.

3. The Intra-Psychic Process

The latest definitive statement about the syndrome known as schizophrenia which has engendered some agreement is that

> "Schizophrenia is a disorder of ego functioning...which results in an inability to separate out and maintain accurate internal mental representations of the outside world. This inability, in turn, causes the production of restitutional symptoms (delusions and hallucinations) which are most prominent when the individual is confronted with the stresses of developing independent, mature trusting adult relationships." (Gunderson and Mosher, 1975, p. XIX-XX)

The ego dysfunction results from an ego deficiency, as evidenced in the fact that for the schizophrenia, concepts and symbols are frequently confused with the concrete objects of their environment. These concrete objects then take on a highly personal significance. The schizophrenic individual often is unable to distinguish fact from fantasy, desire from belief, precept from concept; he or she has trouble discriminating a concrete object from its attributes, a symbol from what it symbolizes. (Grauer, 1955)

The defenses against primitive instinctual impulses and ancient memories against archaic and infantile ways of dealing with the world have broken down. Unconscious content floods into conscious awareness. While the acutely psychotic individual is in direct contact with his or her unconscious, it is understood in the way one understands a dream while still dreaming. The understanding is neither orderly nor

integrated; it cannot help unravel the material, quell the fear. The schizophrenia submits to the unconscious without being able to control it. (Racamier, 1959)

The orderly associations of the ego known as secondary process thinking are disturbed and loosened. Bleuler described the disturbance as an invasion of the disorderly, prelogical, concretistic, and reality-distorting associations of the id (the primary process). Primary process thinking lacks the limitations on mental content that usually come when one can consider reality as it actually is. It is a process which abandons the logic of time and space relationships, appropriateness, causal sequence, and concern over whether one's communications are understandable. Hallucinatory wish fulfillment, with its immediate if illusory satisfactions, replaces appropriate efforts to achieve the more delayed but more real gratifications in reality. (Knight, 1952)

Several writers compare the schizophrenic to the dreamer. It is a good parallel. According to Frederick Redlich (1952), there are many similarities between the dream and schizophrenia. For example, common to both are

> "Intellectual and emotional dissociations, various degrees of regression to magical thinking, blurring of the boundary between self and reality, projection, condensation and replacement of secondary, logical thought processes by primary, irrational wish-fulfilling processes." (p.22)

The thinking of the schizophrenic has been compared not only to dream processes but also to the thinking of small children, and the quality of thinking found in primitive cultures. It is thinking which does not differentiate between the concrete and the metaphorical

or symbolic. (Searles, 1965; Arieti, 1955; Lidz, 1965)

> "Thus we might say that just as the schizophrenic is unable to think in effective, consensually validated metaphor, so too is he unable to think in terms which are genuinely concrete, free from an animistic kind of so-called metaphorical overlay." (Searles, 1965, p.561)

In an example of metaphorical overlay, one client reported that she lined up the pencils on her desk because she felt that the pencils wanted to be next to each other. This happened at a point in the transference when she was beginning to feel some sense of separateness from the therapist. Her confusion between concrete and symbolic, the displacement of her unconscious wish onto the pencils, illustrates the quality of this thinking. The fact is that "without the establishment of firm ego boundaries, a differentiation between metaphorical and literal meanings cannot take place." (Searles, 1965, p.583)

Searles (1965) postulates a direct connection between one's awareness of emotion and symbolic thinking.

> "I think it is enough to conclude that the awareness of emotion--whether murderousness, tenderness, grief, or whatever; awareness of the whole spectrum of emotion--is the father to metaphorical thought and, perhaps in the same way, to all forms of the symbolic thought which distinguishes the adult human being." (p.572)

The capacity to engage in metaphorical or symbolic thinking requires the ability to understand the nature of things, that is, to understand the essence of an event or an object. The first basic distinction we all must make is to learn what is inside and what is outside, i.e., what is me and what is not me. This is the beginning of reality testing.

> "The ability to perceive individual differences in those around us depends on the extent of the subject's self-object differentiation. Greater degrees of self-object differentiation permit more acute reality testing. Lesser degrees of self-object differentiation are concomitant with a greater frequency of projection, denial, and impairment of the ability to distinguish between projections on to, and the nature of, external objects." (Borowitz, 1970, p.132)

Searles (1965) links awareness of one's emotions to the development of ego boundaries, the experience of being a separate person.

> "The child fails to proceed through the normal developmental phases of symbiosis and subsequent individuation; instead, the core of his personality remains unformed, and ego fragmentation and de-differentiation becomes powerful, though deeply primitive, unconscious defenses against the awareness of ambivalence in the object and in himself. Even in normal development, one becomes a separate person only by becoming able to face and accept ownership of one's ambivalent feelings of love and hate towards the other person." (p.524)

Searles repeatedly emphasizes the primacy of the emotions in this disorder. The combination of the schizophrenic's inability to tolerate his own love and hate, together with his inability to recognize or accept any ambivalence in the object creates such anxiety that extra-ordinary defenses are called upon for protection. These defenses can and do involve the entire structure of the personality. Searles wrote:

> "My point is that not merely specific ego functions, such as perception, may become sacrificed in the service of unconscious defense against anxiety (from whatever source), but that even the very boundaries of the ego itself may fluctuate, may be in large part relinquished in the last-ditch struggle against anxiety of psychotic proportions," (1965, p.566)

The thought disorder is understood as a defense, i.e., "the function of concrete thinking (is) in maintaining under repression various anxiety-laden affects." (Searles, 1965, p.572)

It seems that Searles views the intrapsychic structure of the individual as either a tool or a weapon. It can focus reality, which then clarifies one's ambivalent feelings or it can protect against invasion of overwhelming feelings. Therefore, when feelings become intolerable, the structure is dismantled. One is thereby protected from knowing. In summary, Searles views schizophrenia as an illness system functioning as a defense against the awareness of emotion. Regression to a state of dedifferentiation of self from non-self, or to a state of ego fragmentation, "should be thought of as not merely rather fixed levels of maturation or regression at which a patient exists over a long period of time, but as flexible defenses of the ego against overwhelming anxiety." (Searles, 1965, p.316)

4. Clinical Manifestation

Basically there are two diagnostic approaches to schizophrenia. One, espoused by Kraeplin, emphasizes the bizarre--the frequent presence of paranoid and grandiose delusions, the occurrence of auditory and other hallucinatory experiences. The second approach, espoused by Bleuler, postulates dissociative thinking as the primary symptom. Bleuler also postulated three other main symptoms: disturbances of affect; ambivalence of affect, intellect and/or will; and autism. They have recently been deemphasized since they cannot be specified and mean different things to different clinicians. (Carpenter and Strauss, 1979)

In spite of the passage of time, Bleuler's and Kraeplin's models for identifying the pathology are still used. The Diagnostic and Statistical Manual of Mental Disorders,(Third Edition) 1980 combines these two approaches. It lists as important symptoms: delusions and hallucinations (particularly auditory hallucinations) and disturbances in the form of thought. The term disturbances in the form of thought refers mainly to loosening of associations and povery of content of speech. Loosening of associations is

> "A disturbance of thinking in which ideas shift from one subject to another in an oblique or unrelated manner. The speaker is unaware of the disturbance. When loosening of associations is severe, speech may be incoherent." (American Psychiatric Association, 1980A, p.86)

Povery of content of speech can be defined as replies that are long enough but convey little information. Language tends to be vague, often overabstract or overconcrete, repetitive and stereotyped. Sometimes it sounds like "empty-philosophizing."

D.S.M. III designates three other symptoms which create major difficulties in the sphere of interpersonal relations. The first is a disturbance in the individual's sense of self. These clients say such things as "Mary is not a person" when referring to themselves and their experience of themselves--which does not permit use of the personal pronoun "I." The second, a disturbance in volition. These clients often do not initiate any goal-directed action. Finally, there is often withdrawal from the external world into one's inner world. Friends, relationships, and job hold little meaning.

In summary, there is disagreement regarding the etiology of schizophrenia. The manifestations of this syndrome resemble the

autistic and symbiotic phases of infant development. There is agreement that schizophrenic thinking is markedly different from normal thinking. Whether resulting from an organic deficit or a functional defense, the schizophrenic is unable to separate out and maintain accurate internal mental representations of the outside world. Secondary process thinking has been disrupted. There is a regression to primary process thinking. The personality regresses from a differentiation of ego, id and superego to a state of dedifferentiation with consequent impairment of reality testing. Searles understands this regression as a defense of the ego against overwhelming anxiety and intense ambivalence. Hallucinations and delusions are considered primary symptoms by some diagnosticians while others consider these as restitutional symptoms.

SEARLES' THEORY OF TREATMENT

1. Overview

Searles' treatment approach is a developmental one. Following Harry Stack Sullivan, Searles views human development as possible only through the medium of interpersonal relations. Similarly, development and change are accomplished only in response to a significant other.

> "Because the schizophrenic patient did not experience, in his infancy, the establishment of, and later emergence from, a healthy symbiotic relatedness with his mother such as each human being needs for the formation of a healthy core to his personality structure, in the evolution of the transference relationship to his therapist he must eventually succeed in establishing such a mode of relatedness." (Searles, 1965, pp. 338-339)

The resolution of a healthy symbiosis permits and fosters separation and individuation. It is a process that can be reexperienced in therapy.

When it is, the individual will have the opportunity to reexperience that development phase, in a healthy fashion. Whether this process occurs depends, at least in part, upon the therapist's ability to enter into a symbiotic relationship with the client, subsequently relinquish the symbiosis and once again view the client as a separate individual. This process is similar to what occurs in any dynamically oriented psychotherapy where the therapist must "start where the client is." However, a more neurotically structured client has achieved a higher level of development and this places qualitatively different demands on the therapist. The transference relationship reflects differing needs. It is clear that the emotional needs of a five-year-old are different from the emotional needs of an infant. For example, although difficult, a five-year-old can tolerate the absence of his parent for a week or two, whereas "an infant and toddler cannot stretch his waiting more than a few days without feeling overwhelmed by the absence of his parents." (Goldstein, Freud and Solnit, p.40) Similarly, a neurotic client can maintain enough connection with a therapist seen once a week to sustain the therapeutic work. A schizophrenic client is unable to maintain a feeling of relatedness and safety over so long a period. This schizophrenic client's task is to experience symbiosis and resolve it. This process enables the development of ego boundaries and a sense of identity. It also requires far greater investment on the therapist's part in terms of time and emotional involvement, than does work with a neurotic client. After all, a toddler is far more demanding of mother than a five-year-old.

During this process, behavior once seen by the therapist as alien and bizarre must come to have meaning for the therapist. In order for it to lose its alien and dissociated quality for the client, it must acquire the meaning of a personal communication. For example, one client is largely silent during the therapy hour. At first, I viewed her silence as terror, as crippling anxiety, as her fear of exposing her "crazy" thoughts. Eventually, I began to experience her silence as resistance, as her refusal to allow me "in," her means of keeping our relationship impersonal. The appearance of our relationship did not change. There was still silence. However, I experienced a heightened sense of involvement and a corresponding frustration at being excluded from her experience. Her silence no longer felt bizarre. It felt as though she purposely excluded me and kept me out, giving me the same "silent treatment" she gives her mother. I understood her silence in a different context. The client's mother is described as very obtrusive, emotionally flat and asthmatic. One can understand this client's need to defend against being intruded upon and taken over by her mother's flatness; and yet, open opposition was too dangerous as it might "cause" her mother to have an asthma attack. The silence and resistance to revealing herself can be seen as an attempt to preserve herself and an expression of angry exclusion. Her silence became a comment on our relationship or a comment on her feelings about me as a transference figure. When any aspect of behavior is viewed as information about a person or a personal relationship it no longer contributes to feelings of dissociation. Searles believes that integration must first

occur interpersonally and only then becomes internalized.

The therapist's new understanding of a client's behavior will alter the subtle and direct communication between them. The client will respond to the therapist's new perception. Thus, the therapist's understanding can introduce reality into the client's thinking and diminish bizarre behavior. An analogous process occurs between a mother and her new infant. The mother learns to differentiate her baby's cries, she learns which cry means hunger, which fatigue, which some other discomfort. She responds appropriately. In time, her appropriate responses help the baby to begin to differentiate one discomfort from another.

Searles identifies four phases of therapy with a schizophrenic: The phase of pathologic symbiosis, the autistic phase, the symbiotic phase and the phase of individuation. Searles acknowledges that much of his knowledge about these phases grew out of his observations of his countertransference. Along with Heimann (1950), Cohen (1952), and Weigert (1952, 1954), Searles believes that the "analyst can learn about the patient from noticing his own feelings, of whatever sort, in the analytic relationship."(1965, p.285) He identified his own phases of relating and found that he went through various phases in the relationship that repeated themselves as a consistent sequence with other schizophrenic clients. He also found that clients enter treatment at various stages, and that with those who enter at a higher stage of ego development, therapy will naturally begin at the second or third phase. He found a direct correlation between an individual's ego development and the phase of therapy that

individual enters. Those individuals who enjoy a higher state of ego development begin therapy at a correspondingly advanced phase.

2. The Phase of Pathologic Symbiosis

In this first phase, the client tries to develop a pathological alliance with the therapist by trying to evoke feelings and behavior that conform to the client's projection. The result is a complex of unconscious identifications with the therapist, which the client bases on those projected aspects of himself. Cohen (1952) observed this phenomenon:

> "It seems that the patient applies great pressure to the analyst in a variety of non-verbal ways to behave like the significant adults in the patient's earlier life. It is not merely a matter of the patient's seeing the analyst as like his father, but of his actually manipulating the relationship in such a way as to elicit the same kind of behaviour from the analyst. (p.240)

According to Searles, the repeated assaults by the client's projections result in the therapist experiencing feelings which are inappropriate.

> "If the patient reacts persistently and vigorously and long enough to the therapist as being a mother who has intense but dissociated murderousness, the therapist will in all probability come, one day to find himself frightened at seeing how powerful are the murderous feelings which have grown up in him toward the patient." (1965, p.345)

> "These are the patients who have little healthy ego of their own but are, instead, a constellation of vengeful identifications with other persons, present and past. These identifications, because of the hatred and guilt and unworked-through grief which have attended their installation

> in the patient's personality, are indigestible by his ego; hence his unconscious effort to rid himself of them, to expel them into the therapist."(1979, p.135)

Searles believes that the client will eventually move out of this first phase. The movement can be encouraged by the therapist's refusal to function in a fashion that supports the client's projections. The therapist is free not to react by recognizing that his feelings are based on what he introjects from the client. The therapist's refusal to participate in this pathological symbiosis forces the client to regress from the symbiotic phase of development to the autistic phase. Although the schizophrenic client has achieved a symbiotic level of functioning, it is not a healthy or helpful one. The first major task of therapy is to create an atmosphere which will allow the schizophrenic to yield up this unhealthy symbiotic relatedness and regress developmentally to a more autistic level of functioning. The regression is similar to the optimal regression facilitated by a therapist in any psychoanalytic theory. (Greenson, p.85)

3. The Autistic Phase

Searles' use of the term "autism" refers to a developmental level that is close to Mahler's autistic phase of development. Mahler (1975)described this first phase of infant development as being the time when the infant has a "quasi-solid stimulus barrier--the autistic shell which kept external stimuli out." (p.44) Searles believes that the schizophrenic erects a similar stimulus barrier. According to Searles (1965), there occurs:

> "A regressive dedifferentiation toward an early level of ego-development which has its prototype in the experience of the young infant for whom inner and outer worlds have not yet become clearly distinguishable as such." (p.525)

Searles clarifies that in the autistic phase there has been a regression of the intrapsychic structure to the earliest developmental level.

> "To the degree to which a patient functions autistically, he or she has not achieved a clear differentiation between, and integration among, such realms of experience as thinking, feeling emotions, and feeling bodily sensations."(1979, p.153)

Thus, Searles' use of the term autism is close to Mahler's. The essence of the "quasi-solid stimulus barrier" Mahler describes seems quite in evidence in the following excerpt from Searles' first book (1960):

> "It was only...as she (the schizophrenic patient) started to move out of her very long-standing psychosis, that she began to be extremely irritably conscious of the real world about her, including myself during the therapeutic hours. Previously, I had been amazed, many times, at her utter obliviousness to any sounds on the disturbed ward where the hours were held." (p.378)

Searles described how upset he became at the terrified screaming and raging on the ward and how he "marvelled at the degree of apartness from all this which she had achieved." (p.378) He noted, during this autistic phase, that although the woman spoke to him fairly and freely, she did so without relating to him emotionally.

Not being emotionally related to is a difficult experience for anyone, tantamount to being nagged. It is especially difficult for

a therapist, whose professional value is contained in the ability to relate in an interactive manner. Talking without relating, the absence of a connection denies professional existence to the therapist. It also requires the presence and demands the attention of the therapist. During the autistic phase, there is often a considerable period of time when the therapist feels irrelevant, unresponded to and insignificant. This is especially true when dealing with a silent or deeply delusional client. For example, after many years, one schizophrenic client reported that during the first many months of therapy, when conversation seemed to flow so freely, she continued to come to therapy only because I seemed so nice. She "loved to complain," but felt no connection. Neither therapist nor therapy had any significance for her.

Searles believes the therapist's feelings for the client suffer as a consequence of the client's inability to relate. He described a reciprocal interaction wherein the client can only feel alive to the therapist when the therapist feels alive to the client.

> "Characteristic of this phase is that the patient's feelings are unavailable to him and not conveyed in his interpersonal relationships; hence the therapist experiences comparatively little in the way of feeling responses to the patient's behaviour, except for a sense of strangeness, of alienness, in reaction to the bizarre symptomatology into which the patient's feeling--potentialities have long ago become condensed--the hallucinations, the delusional and neologistic utterances, the stereotyped and manneristic nonverbal behaviour, and so on." (1965, p.525)

Consequently, during this autistic phase, the therapist experiences aloneness and isolation, experiences being "thrown back upon his own

capacities for autistic experience." (1979, p.151)

4. The Symbiotic Phase

The symbiotic phase of therapy is characterized by the therapist overvaluing him or herself, the client and the relationship, and a sense of aliveness and fulfillment in the therapy. It grows out of the autistic phase, during which there is a progressive weakening of ego boundaries between the therapist and the client. Each person in the therapeutic dyad slowly and gradually begins to invest the other with importance. Each becomes sensitized to the other's verbal, facial and postural expression; a quality of knowing each other develops. A feeling of bond, perhaps projected initially only by either therapist or client, comes to be a shared experience. Slowly, there evolves a "reality basis for the symbiotic transference which the schizophrenic patient tends powerfully to form with his therapist." (Searles, 1965, p.532)

This progressive attachment between therapist and client constitutes what is termed a therapeutic symbiosis. It is the crux of Searles' treatment approach. The achievement of a healthy symbiotic experience in the transference, and its subsequent resolution is, in Searles' theory, the curative factor.

> "The patient needed to come to experience the analyst as being equivalent to the early mother who comprises the whole world of which the infant is inextricably a part, before he has achieved enough of an own self to be able to tolerate the feeling-experience of sensing her as a separate from his own body, and the two of them as separate from the rest of the actual world." (1979, p.163)

Differentiating a pathologic symbiosis from a therapeutic one can be difficult, since there are many similarities. In each, the other individual in the dyad is overvalued and believed vital to one's sense of wholeness. Searles comments on the difficulty distinguishing between the two and offers the following contrasts:

> "Whereas in pathologic symbiosis the patient and therapist form two relatively fixed, complementary parts of the whole system, in therapeutic symbiosis both persons function in thoroughgoing and rapidly changing flux and interchangeability, with all parts of potentially whole and separate persons, and, far beyond that, whole and separate worlds, flowing from and into and between, and encompassing, both of them. Also the affective tone of therapeutic symbiosis is one of liveliness of contentment or fulfillment, while that of pathologic symbiosis is one of constriction, incompleteness, unfulfillment, or inner disturbance to the point of threatened insanity."(1979, pp.134-135)

The therapist's experience varies as the therapeutic relationship moves through each phase. In the therapeutic symbiosis phase, the therapist feels more positively, both towards the client and towards him or herself. The client is more receptive to the therapist's comments, interpretations, and clarifications and responds to them. Both therapist and client feel connected and the therapist can feel significant.

The therapeutic symbiosis is a reenactment, within a transference relationship, of the client's early relationships. Often, the parent-infant roles becomes blurred. At times it is not clear who is the client-infant and who is the therapist-mother. The role confusion may be indicative of the role confusion the client experienced growing up. The schizophrenic is not only a disturbed,

distressed human being, but usually also a caretaker. Each of my clients reports being keenly aware of the mother's fragilities, behaving so as not to upset mother. For one client, this meant never establishing any relationship outside the family that might exclude mother. Searles, among others, recognized that the schizophrenic client played a therapeutic or mollifying role in his or her own family. The client's "most deeply meaningful human relationships consist in his complementing the areas of ego incompleteness in other persons." (Searles, 1979, p.175) Particularly, the client complemented mother's ego incompleteness. No matter how upset these clients may feel, I have yet to find an instance when they are not simultaneously totally alert to me and my well being. The client's concern is neither altruistic concern nor compassion. Rather, it grows out of their history of being dependent for survival on a parent whose emotional state was inconsistent and whose level of distress affected both the quantity and quality of care given to the client. On one occasion, I did not understand the meaning of a client's leaving the office in the middle of a therapy session. I learned she left in order to protect both herself and me from the consequences of what she believed to be murderous rage. On another occasion, I did not understand the meaning of another schizophrenic client's refusal to accept an additional appointment at a time when she was unusually upset. I came to understand that her refusal was not resistance, but was her response to the fatigue she heard in my voice. I had ignored my fatigue--she could not. She could only assure herself of my good care by protecting me from my

unrecognized fatigue. In effect, I repeated her family's lack of recognition of my client's efforts, by not understanding her efforts on my behalf.

> "It is equally important that the therapist become able to accept his nursing-infant fantasies toward the patient, whether female or male, for otherwise the patient cannot learn deeply to accept his own desires to nurture--the primeval basis of all givingness."(1965, p.540)

The client's therapeutic efforts in their own families were never recognized nor validated.

> "One of the most heavily defended emotions in the schizophrenic patient is his sense of guilt at having failed to enable his fragmented mother to become a whole and successful mother to him." (Searles, 1979, p.177)

For a therapeutic symbiosis to occur, the therapist must be as intensely involved as is the client. The therapist must be open to accepting his or her own feelings of love and hate for the client. This is a level of involvement not usually considered appropriate to the therapist's role. Searles, however, considers such involvement essential. He describes it as, "a relatedness such as normally holds between the young infant and his mother, in which the participants are subjectively one with each other."(1965, p.409) He notes, "one simple earmark of this phase...is that the relationship with this patient has assumed an absorbing, unparalleled importance in the therapist's life."(1965, p.533)

A therapist is taught the importance of not needing one's client. Emphasis is placed on the therapist's ability to monitor feelings towards one's client so as not to utilize a client for one's own

ends. Searles emphasizes another aspect, that of allowing and accepting the client's value to the therapist without needing the relationship for one's own ends. According to Searles, the therapist's own analysis can serve this end. Searles believes that personal analysis will free the therapist to fully participate in the symbiosis without using the relationship to the client's detriment. He cautions therapists "to try to see whether this (the therapeutic symbiosis) is occurring, and to try not to interfere with its development, rather than to feel guilt, shame, or fear about this state of affairs." (1965, p.410)

5. The Individuation Phase

Both participants feel the need to pull away from each other, so as not to be burdened. Yet the loss of the symbiotic relatedness is at times experienced and longed for. Searles (1965) describes the therapist's feeling "out of love with the patient," "a sense of apartness from the patient...a realization that he is a person 'over there'." (p.544)

> "On other occasions, the therapist experiences a resolution of the symbiosis...with a sudden sense of outrage...he feels outrage at this or that chronic regressive symptom...and always outrage at the unreasonableness of the demands which the patient has been making on him these many months...and sees clearly the folly of acquiescing further in these regressive demands." (p.544)

My experience with this phase confirms Searles' theory. In one instance, I suddenly felt furious. After three and one-half years of therapy, my client seemed to be making progress. She suddenly regressed and began to relate to her delusions and "voices."

As she had so many times before, she again threatened to look in the streets for glass with which to cut herself. I felt depleted, as though all my efforts on my client's behalf were worthless. I felt swamped by her demands. Rather than concern, I experienced great concern for myself--that I might be taken over by her needs. For that moment I no longer cared whether she killed herself. I no longer experienced myself a concerned therapist.

> "One now holds the patient highly responsible for his symptoms. One... leaves in his hands the choice as to whether he wants to spend the remainder of his life in a mental hospital, or whether he wants, instead, to become well...one cares not, now, how callous this may sound, nor even whether the patient will respond to it with suicide or incurable psychotic disintegrations;...Thus, in effect, one braves the threat of destruction both to the patient and to oneself, in taking it into one's hands to declare one's individuality, come what may." (Searles, 1965, p.545)

Dramatic as Searles' description sounds, it accurately describes my experience.

The individuation phase is the first one that resembles any phase of therapy with less disturbed clients. The schizophrenic client is only now able to integrate cognitive and emotional knowledges. For example: The client begins to recognize and tolerate conflicting feelings and to experience grief over the loss of idealized parental images and childhood hopes. These therapeutic advances are first experienced in the interpersonal relationship with the therapist and then they become intrapersonal processes.

As is similar with other clients during later stages of therapy, the schizophrenic clients now also begin reporting new or renewed interests. Recreative and creative endeavors become of interest to the client. Usually, during this phase of individuation, the therapist feels left behind. He or she is no longer the center of the client's universe. The client gives evidence of taking responsibility for developing insight into his or her own psychotic behavior.

SUMMARY

In this chapter, an outline of the basic features of the schizophrenic disorder and a summary of Searles' treatment approach were presented. In the description of the phases of therapy it has been shown that the attitude of the client indicates the status of the relationship and therefore informs the therapist as to the current phase of therapy. The following chapter will integrate Searles' interpersonal approach to therapy with schizophrenics with Racker's conceptualizations about countertransference. The integration will indicate how countertransference can reveal the client's attitude towards the therapist.

CHAPTER 6

THE USE OF COUNTERTRANSFERENCE IDENTIFICATIONS IN PSYCHOTHERAPY WITH SCHIZOPHRENIC CLIENTS

INTRODUCTION

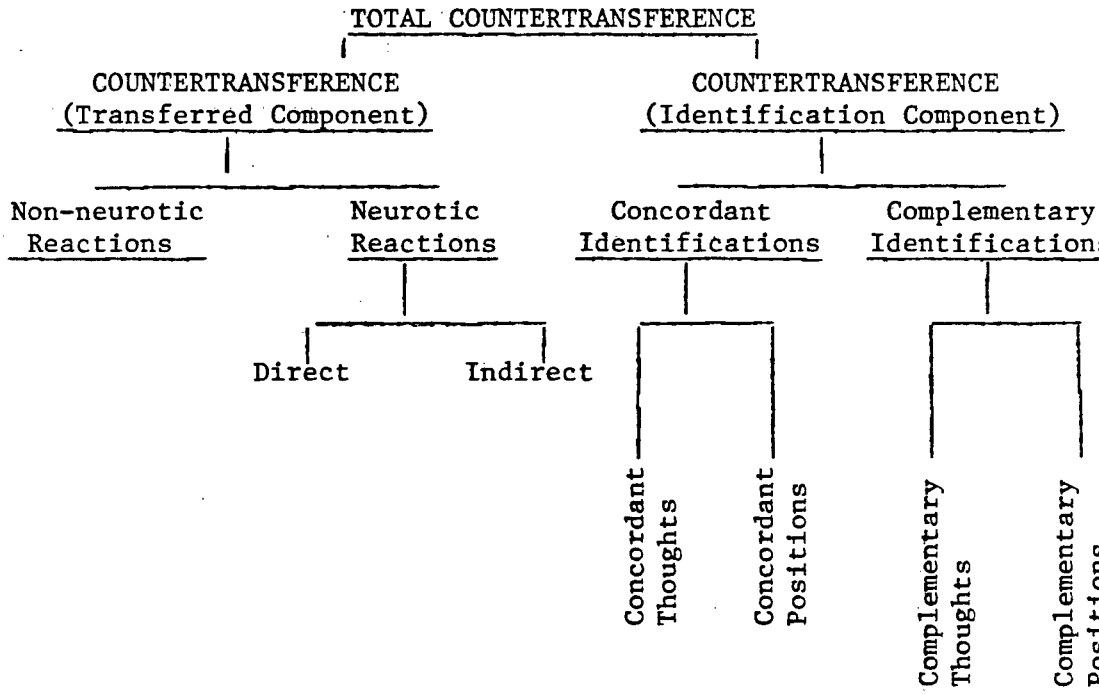
This chapter demonstrates the value of applying Heinrich Racker's conceptualizations to clinical data. It also demonstrates how countertransference data can elucidate the psychic processes at work in the schizophrenic client. After a brief review of Racker's theory, this chapter focuses on the early phases of therapy, and particularly on how the therapist's self-experience is affected by the client. The first research sub-question is then addressed: Can countertransference experiences be used to identify whether the schizophrenic client experiences the "realness" of the therapist's existence? That is, does the client know that the therapist is a person, alive in the room at the moment, and not someone from the client's past or a hallucination or a non-human entity? Next, clinical data related to individuation is examined, focusing on the treatment process at the time when client and therapist are resolving the therapeutic symbiosis. Particular attention is directed onto the countertransference experience. The second research sub-question is addressed next: Can countertransference experiences be used to identify the extent to which a schizophrenic individual can differentiate self from other? Finally, the main research question is addressed: Can countertransference reactions be used to identify the emotional attitude of the schizophrenic client towards the therapist, as well as detect changes occurring in that attitude?

RACKER'S THEORY OF COUNTERTRANSFERENCE

According to Racker, one's countertransference can be a rich source of information when the therapist examines personal reactions. Countertransference responses can give information about the therapist, about the client, and about the client's internal objects. Racker viewed countertransference as the whole of the therapist's images, feelings and impulses. In part, these responses are determined by the therapist's past relations (especially those with significant others, e.g., family) and in part, by the therapist's realistic and neurotic needs. In addition, countertransference is determined by the therapist's identification with the client's personality (id, ego and superego) as well as with the client's internal objects.

Concordant identifications occur when the therapist's feelings are in accord with and parallel to the client's. The term is synonomous with the process known as "empathic identification." (Weigert, 1951) Complementary identifications occur when the therapist's feelings form a counterpart to the client's feelings. They occur when the client recreates an earlier relationship and does that so effectively that the therapist feels and acts as did the original object. It is as if the client had projected his image of a childhood figure onto the therapist with such intensity that the therapist accepts the projections and acts accordingly. Racker further distinguished between countertransference thoughts and countertransference positions, the latter being a much more intense and disconcerting experience for the therapist. Countertransference thoughts, Racker believed, originate in projected thoughts that are out of the client's immediate awareness but are ego

syntonic whereas countertransference positions have to do with impulses, feelings and images that are disavowed by the client and are ego alien. Racker's conceptual model of countertransference is schematically depicted as follows:



This project is not concerned with the information the therapist gains from the countertransference experience about him or herself. Rather, this project focuses on the use of countertransference for information about the client and his or her internal objects. The method employed involves several steps which can be delineated as follows: (1) The therapist becomes aware of and observes a counter-transference response; (2) the therapist speculates about the source of the countertransference response, (A) "Based on my knowledge of this client, is is possible that I am experiencing a concordant identification?" or (B) "Based on my knowledge about the client's

perception of significant others, am I experiencing a complementary identification?"; and (3) clinical observations are used to verify or negate the therapist's speculation. These processes are demonstrated in the clinical examples offered in this chapter.

COUNTERTRANSFERENCE DURING THE PHASES OF PATHOLOGIC SYMBIOSIS AND AUTISM

According to Searles, the autistic phase of therapy challenges the therapist's capacity for autistic experience. Racker's theory indicates that the therapist's experience may involve more than personal autistic productions. The therapist may be involved in communication outside of his or her awareness. In order to relate to the client, the therapist must be open to an empathic identification and thus be receptive to the client's projections. This approach suggests two spheres of therapist experience: (1) The therapist experiences not being related to at all, or not being related to in a familiar manner; and (2) the therapist's feelings of self undergo a temporary alteration as a result of the client's projections. What Searles terms the therapist's autistic process may actually be an identification with the autistic client, a concordant identification in Racker's terms. This view can dramatically alter one's understanding of the following passage by Searles (1979):

> "In my recent papers...concerning autism I have described how the analyst is thrown, in response to the autistic patient, back upon his own autistic processes. A development which comes eventually to contribute to the resolution of this autistic mode of relatedness is the analyst's surprised, recurrent, and deepening realization and

> acceptance of the fact that these two seemingly so-separate worlds, his world and that of the patient, are but separate outcroppings of the unconscious ground joining the two of them." (p.191)

What Searles calls the "unconscious ground joining the two of them" is the autism. The therapist has introjected the client's autism and now experiences it as his or her own. The autistic experience may be the result of a concordant identification with the client, or it may be the result of a complementary identification, an identification with the client's internal object. Searles (1979) suggests that the client's autism may be a withdrawal from identifying with depression, insane or otherwise autistic mother. (p.171) One can anticipate that a client who experienced his mother as incapable of relating in a meaningful way, would project that internal object onto the therapist. As a result, the therapist will experience a complementary identification with the client's internal object.

The following example illustrates a pathologic symbiosis and the way in which a therapist can be caught up in a complementary position vis-a-vis the client (that is, the way in which a therapist can unwittingly act out the client's projections).

EXAMPLE #1

> A 36-year-old schizophrenic woman whom I have been seeing twice a week for over four years still speaks only when spoken to and even then, usually only answers questions with the briefest of replies. She does nothing on the days she is not at work; she sits at home. She goes nowhere on her own, not to a movie, for example, for doing so will make it clear to everyone that she has no friends, and will make her too acutely aware of her feeling of not being

> connected to anyone. She cannot read she reports, as she cannot concentrate, so she sits. She is very unhappy and she will tell me what a terrible day she has had if I ask. Over the years, I have urged her to do one thing or another, e.g., go out for a walk; none of this has been acceptable to her. She finds my suggestions irritating. Finally, I recognize how pressured I felt to do something helpful. I assumed that she must feel pressured by my suggestions and intimated that to her. She acknowledged that this was the case. I then said that I could stop making suggestions since it appeared that she felt she had to silently oppose what felt to her like directions just as she had opposed her anxiously intrusive mother who had tried to direct her every action. She agreed that this was her response, a highly perfected form of passive resistance. However, she acknowledged that she was uneasy with my suggestion that I withdraw this "helpfulness" and stop pressuring her.

My pressuring her, via my suggestions, acted out the complementary identification. This client and I were in a phase of pathologic symbiosis. She experienced her familiar sense of self because she could feel herself opposing me as she had silently opposed her mother. Her silent opposition allowed her to stay connected to me (as she had to her mother). I unconsciously became the pressured and pressuring mother and so behaved. Obviously, the client could not accept my suggestions so long as I was invested in them, for then her success would not be experienced by either one of us as her success, rather as mine. At the same time, since this is the only way she was ever related to, I might have been able to anticipate the role she would have me play, had I understood complementary countertransference.

In response to a similar therapeutic struggle, Searles (1965) instructed therapists as follows:

> "In working with the patient during weeks or months of silence on the latter's part, he will not, out of a compulsion to help the tragic victim of schizophrenia, rack his brain with diligent therapeutic efforts focused upon the patient, who is already afflicted with overwhelming intrapsychic pressures." (p.529)

In pressuring the client, the therapist may be reacting out of a compulsion. It poses a question, however, of whether the therapist's pressure is an attempt to ward off a sense of helplessness and futility, or whether the therapist is unknowingly acting out a complementary identification. It becomes important, therefore, to examine the possible reasons for a therapist to feel a compulsion to "help." In the above example the compulsion was based on the therapist's inappropriate investment in the client's activity. I behaved as if I were indeed the client's mother. The therapist and client replicated the mother-client relationship. The client needed to project the anxious maternal internal object into the therapist, thereby creating a complementary identification for the therapist. At some point, the therapist and client became conscious of what occurred. Racker (1968) summarized a similar situation when he wrote:

> "One might object that this confusion between the analyst and the superego neither can nor should be avoided, since it represents an essential part of the analysis of transference (of the externalization of internal situations) and since one cannot attain clarity except through confusion. That is true; this confusion cannot and should not be avoided, but we

> must remember that the confusion will also have to be resolved and that this will be all the more difficult the more the analyst is really identified in his experience with the analysand's superego and the more these identifications have influenced negatively his interpretations and conduct." (p.160)

According to Searles (1965), "The 'urgently helpful' therapist attitude is unconsciously designed to avert" the unfolding of the autistic phase of treatment so that the therapist can "shield himself... from feeling at a deep level the impact of the fragmented and dedifferentiated world, with its attendant feelings, in which the patient exists." (p.530) Was I, the therapist, warding off this experience or was my client warding it off by projecting her pressuring mother (internal object) into me in order to continue to experience herself as oppositional? Perhaps both occurred. Or, perhaps we united in warding off some greater sense of separation in the transference until such time as either one of us could tolerate it?

Searles and Racker provided differing avenues of thought for answering questions. Racker's theory offers more pertinent information about the client while Searles' theory offers an opportunity for the therapist's self-analysis. Therapists cannot always find answers. In the absence of certainty, a theoretical body of knowledge can help formulate questions, and so utilize and systematize information which might otherwise be lost. Racker's concepts provide a theoretical basis for formulating diagnostic inquiries. They can suggest an alternative way of looking at clinical data. His theory suggests that the client's

intrapsychic conflicts are often acted out in both the transference and the countertransference. This perspective offers an additional dimension of understanding.

If one accepts the concept that countertransference gives information about the client and the client's internal objects, then the therapist's awareness of a response that is unusual for him or her can furnish useful information about the client. For example, the therapist's experience of a lack of customary sympathy or acceptance can provide important information about the client's early objects. (Examples of such a dynamic are offered in this chapter.) Searles (1965) recognized the need to accept unexpected responses or lack of responses, although he did not seem to understand their significance to the treatment process. He stressed the importance of neutral responses, even though "it may indeed severely threaten our sense of humanness." (p.637) He went on to state:

> "Only by a comparatively unanxious acceptance of such responses or such a lack of response in ourselves, can we help the patient to erode through the areas of 'as-if' pseudo-emotion, ostensibly intense emotion which is not truly an indication of deep inner experience but rather a superficial imitative phenomenon." (p.637)

The implication of Searles' comments seems to be that a lack of response or an unusual response in the therapist may indicate a "pseudo-emotion" in the client. In that instance, the only genuine response would indeed be a lack of response. In such an instance, the therapist's lack of response can offer a clue to the client's internal state. Searles (1965) offers the following clinical data:

EXAMPLE #2

> "Early in my work with a hebephrenic woman--to give but one typical example--I at times felt troubled and doubtful of my capacity for human feeling, at finding myself utterly unmoved to sympathy despite her being apparently in the grip of intense and wordless grief: her body was convulsed and wracked by sobs, her face appeared ravaged by grief, and she showed a little child's helplessness to cope with the tears which streamed copiously down her cheeks. Only after many months did it become clear that such behavior arose from introjects of her mother and her maternal grandmother, with whose controllingness-through-weeping the girl had never been sufficiently 'hard' to cope successfully." (p.638)

Using Racker's model, Searles' response can be understood as the result of his being placed in a concordant position. His client identified with an internal object, a precursor of her superego. She then treated Searles just as she had been treated. Racker (1968) described this process:

> "When the patient...identifies himself with the superego, he may place the analyst in the situation of the dependent and incriminated ego. The analyst will not only identify himself with this position of the patient; he will also experience the situation with the content the patient gives it: he will feel subjugated and accused, and may react to some degree with anxiety and guilt." (p.140) (Italics added)

Searles' description of his "troubled" feelings at being "unmoved" by his client's weeping can be viewed as an identification with this woman who herself experienced discomfort at being unmoved by her mother and grandmother, and who experienced her maternal objects as controlling rather than sorrowful. In this example, information about

Searles' client is obtained by applying Racker's concepts to the countertransference experience. The clue came from Searles' urge to respond neutrally. At the time it occurred, it was not yet clear whether his lack of responsiveness signified his client's attitude or the attitude that she perceived her mother and grandmother directing towards her. Further exploration with this client clarified that Searles was in a concordant rather than a complementary position.

Searles gives another example of his feelings. The example again demonstrates how a therapist's experience may be more influenced by the introjections of the client's internal state than is initially apparent. He (1965) begins by sharing his feelings candidly (Searles refers to himself).

EXAMPLE #3

> "After perhaps many months of a 'relationship building' phase of treatment during which he has found much reason to become confident, at long last and after many painful and discouraging rejections, he personally has come to matter to this previously inaccessible patient, it comes as a particularly hurtful rejection to see to what a great extent the patient has been reacting to him not as a person in his own right but rather as the embodiment of some figure in the transference." (p.660)

He goes on to give the clinical material and his reaction:

> "One paranoid woman...used to shriek at me the anguished accusation that I had cut off my hands and grafted there the hands of her long-dead grandmother, in order that the sight of her grandmother's hands, extending from my cuffs, would tear her heart with grief and guilt about this grandmother. For a number of years, she was convinced, similarly, that the head she saw on my shoulders was not really mine, but was that

> of some person or other from her past. The therapist under the impact of transference of this power feels very alone, indeed, with little or no confirmation of himself coming by way of any feedback from the patient." (pp.660-661)

Searles' responses result from his introjection of his client's projection; specifically, this autistic woman has communicated her inner lack of a sense of self.This lack may have resulted from the experience of not being confirmed as herself by those significant to her. Searles' powerful countertransference experience allowed him to identify with this woman. He was able to appreciate emotionally how devastating it is for a child to be related to as if she were someone else. He could appreciate the impact on her of having no confirmation of herself as an authentic person, for he underwent the parallel experience of having no confirmation of himself in the treatment situation.*

In numerous detailed examples, Searles shows how prevalent it is for a schizophrenic client to assume the identity of his or her internal object and to project the self (ego) identity onto others,

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* In this example, Searles' countertransference experience encompassed his feelings about himself, e.g., he felt unconfirmed, alone. Racker defines countertransference as the whole of the therapist's images, feelings and impulses towards the client; indeed, most definitions of countertransference, whether narrow or broad, refer to the therapist's reactions towards the client. The above example described Searles' feelings about himself. It may be recalled (Chapter 2) that for this project, the definition of countertransference includes feelings about oneself, that is, feelings about oneself induced by the way one is being related to by the client. The above examples highlight the need to broaden the definition of countertransference to include feelings and awareness of oneself as well as feelings, images and impulses toward the client.

and then to treat the therapist as that projection. It is also prevalent for this client to treat the therapist in a concrete way as if the therapist were indeed the client's significant other. For the client, the therapist has no separate here-and-now reality, and is not experienced as a new person in the client's life. It is not surprising then, that the therapist's sense of self is powerfully influenced by these projections.

In the fourth example which follows, Searles (1965) described his experience of seeing an apathetic man, hospitalized for ten years on the back ward of a veterans' hospital. Searles described his conscious understanding of the feelings he experienced in the encounter. He stated, "I found solid reason to feel appalled and helpless in the face of the havoc which chronic schizophrenia and the diverse efforts to treat chronic schizophrenia had wrought." (p.655) Searles then described his "tremendous change of view" as he discovered that it was not simply the ravages of schizophrenia he was seeing, but, instead, meaningful behavior on the client's part in the context of the man's relationship with his internal object.

EXAMPLE #4

> "The evidence accumulating, during subsequent months and years, that his ostensible apathy was that of a person who had felt it necessary to bank the fires of his own ambitions and devote himself to staying by a grandmother, and much more importantly, before that, a psychotically depressed father, whose needs--needs to be protected from the daily cares of the world by the patient's more or less constant reassuring presence--took priority over the patient's own life as a boy and as a young man." (p.655)

Searles follows this description with a statement that "the major ingredients of his (the client's) illness were originally derived from the introjection of similar qualities in his father." (p.655) The client's apathy was, therefore, an identification with his father. If the client takes on his father's identity (a complementary identification, according to Racker's theory), one can expect him to project his sense of self onto the therapist, who will then experience a concordant identification. Searles stated that he initially felt "appalled and helpless." Searles was experiencing a concordant identification for one can easily understand how a boy who lives with and supports a psychotically depressed father, can feel appalled and helpless.

As the transference and countertransference evolved with this psychotic man, Searles found himself related to as had been the father, "as a mere shell of a person, a person with a long burnt-out mind, a relic given to unpredictable moods of deep depression punctuated by explosive rages." (p.655) Searles concluded this example with the following sentence:

> "As his transference to me became increasingly coherent and powerful, his own personality functioning became proportionately liberated from illness; but I must say that there were times, during the ensuing months and years, when the transference role which he not so much pinned on to as more or less instilled into me, made me feel somewhat less than my usual robust self." (p.656)

An exploration of the process involved in this example is illuminating. First we see an autistic, apathetic man. As the treatment relationship develops, this man becomes more himself and perceives the therapist as he did his father. The therapist, in turn, experiences

being perceived as the father and actually experiences himself as "less than robust." To reiterate, initially Searles' client adopted the identity of his father (internal object) in order to preserve the object for himself. The therapeutic relationship gave this man a person to project his father "into," and so, he could begin to be himself. Pathologically, the man had "become" his father and needed "to be protected from the daily cares of the world." He took on his father's identity and role. The hospital staff provided a "more or less constant reassuring presence," a presence that was analogous to the role he had adopted as a boy. Initially, the hospital staff (including Searles) was in a concordant position while the client identified with his internal object. When the client no longer needed to preserve his lost object because he could project it into Searles, then Searles' role was the complement to his client's role, and Searles was in a complementary position.

It is possible to conceptualize the pathological process occurring in one of two ways, at any given moment. First, the client takes on the identity of the depressed or otherwise disturbed parent* and then projects the experience of relating to that person onto others. In this instance, the client takes a complementary identification and projects a concordant identification. Second, the client experiences her or himself in a disordered way, as not existing as a person or as having a "bad" self, reflecting the way in which the client was related to in

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* For ease of reading, the word "parent" is used rather than significant other, for in most instances, a psychotic's early relationships determine self perceptions as well as perceptions of others.

early life. The client then projects the identity of the parent onto the therapist and others in the present. In this latter instance, the client is experiencing a concordant identification and projecting the complementary one. In both of these processes the only dynamic relationship is between the client and the client's internal object.

Searles (1979) described how, during the autistic phase, the therapist is "given to feel unneeded, incompetent, useless, callous, and essentially nonhuman in relation to his so-troubled and beseeching and reproachful but persistently autistic patient." (p.148) This description of how it feels to be the therapist during the autistic phase of therapy replicates schizophrenic clients' descriptions of their self experiences while growing up.

DISCUSSION

The four clinical examples given above presented data that illustrated several different countertransference experiences. In the first example, I felt over-invested, pressured and pressuring. In the second example, Searles experienced himself as unresponsive to the point of threatening his sense of humanness. In the third, Searles felt hurt, rejected and unconfirmed, and in the fourth example, Searles felt helpless, appalled, and subseqeuently less than robust. The first example described a complementary identification wherein the client perceived the therapist as the maternal internal object and the therapist so reacted. In the second and third examples, it is postulated that Searles experienced concordant identifications. In the last example, it is postulated that Searles initially experienced a concordant identification with the client and subsequently a

complementary identification as therapy progressed.

In all of the above examples as well as the brief description of the therapist's experience during the autistic phase, it is clear that both the therapist's self experiences and responses are different than is usual. When the therapist does not experience responding to a client in a usual and familiar mode, and when no personal life circumstances can account for the unfamiliar experience, and when the peculiarity appears to be specific to a particular treatment relationship, the therapist may be reacting to being misidentified or unacknowledged by the client. The therapist's experience of feeling "not oneself" in the treatment session may parallel the client's inability to experience the therapist as an actual person. In that instance, the client is either in the pathological symbiotic or autistic phase of the transference.

The research sub-question: "Can countertransference experiences be used to identify whether the schizophrenic client experiences the "realness" of the therapist's existence?" can then be answered affirmatively. This is especially so when the definition of countertransference is broadened to include the therapist's experience of self in the therapy situation.

COUNTERTRANSFERENCE AND THE PHASE OF INDIVIDUATION

In this section two clinical examples illustrate the therapeutic interaction and the therapist's reported countertransference experience. A clinical example from Searles' writings is given. The clinical example given in Chapter 5 is further elaborated. Following these examples is a theoretical exploration of them. The second sub-question

is addressed then: Can countertransference experiences be used to identify the extent to which a schizophrenic individual can differentiate self from other?

Searles (1979) reported the following:

EXAMPLE #5

> "I shall never forget the sense of achieved inner freedom which enabled me to tell a hebephrenic woman, in relation to whom I had been enmeshed in anguished symbiotic relatedness for years, that I would never allow her to visit my home--as she long had yearned to do--even if my refusal meant that she would stay in a mental hospital all her life. Where does one draw the line, in such matters, is an expression of the analyst's individual self; this is where I draw the line. Theoretically, it is not essential, and it may be unwise, although in my experience rarely if ever disastrous, to say these things to the patient; the important thing is that one becomes able to feel them--to feel, in this instance, a degree of intense rejectingness which I had projected for years upon this, in truth, remarkably rejecting woman." (p.179)

I had a similar experience with a schizophrenic client.

EXAMPLE #6

> The client is a 28-year-old woman whose first overt psychotic episode occurred at 18 years of age when she moved away from her family. She, however, did report visual hallucinations as early as age four and also described an organized delusional system operating since childhood. She had numerous short hospitalizations since age 18, the longest of which was of nine months duration.
>
> I shall never forget my reaction to this client when, after three and one-half years of therapy, and some evidence of progress, she suddenly resumed relating almost entirely to her delusions and "voices." She again resumed her threats to look for

> glass in the street with which to cut herself. Suddenly, with no warning, I felt furious. I also felt used up. I felt as though all my efforts had been worthless. I felt swamped by her demands. Rather than experiencing concern for her, I experienced concern for myself, that I might be taken over by her needs. I neither cared whether she got well nor whether she killed herself. I certainly did not experience myself as the concerned therapist.
>
> I reacted by establishing some rules and changing others. I informed her that I would no longer see her five or six days a week, depending on her level of distress, but that I would see her only three times per week on an established schedule. I did give her permission to telephone as often as she needed, but I would see her only during the established appointments. I also refused to continue seeing her for no fee. She was on a government pension due to her psychiatric disability, yet I required that she begin payment for her therapy although at a nominal rate.
>
> At the time, it seemed necessary to institute both of these changes in order to re-establish the structure of the therapist-client relationship; that is, to provide the therapist with a sense of structure and control. The changes reaffirmed my boundaries and my identity as the person in charge. By standardizing and reducing the number of appointments and connecting a fee to them, I gained some emotional distance and sense of separateness from the client's needs and demands. I no longer felt invaded.

Both of these examples are situations in which the therapist's need for familiar self definition surfaced and necessitated a break in the symbiosis. This raises many questions. Does the surfacing of the therapist's need for self definition in the therapeutic relationship have any connection with the client's need for separateness? If so, how? Are we to assume that the therapist only becomes aware

of these needs when the client is ready to tolerate the shift? It appears that the therapist, who denied needs for individuality in "selfless" devotion no longer finds sufficient gratification in that stance. If so, could that indicate that the client is not emotionally "paying off," i.e., gratifying the therapist, as had been the case? Or, could it mean that the therapist neurotically got what was needed and is now ready to let go, much as a sated diner leaves the dinner table? Are we dealing with the therapist's neurosis, or with the client's subtly shifting emotional needs? In these two examples, the therapists left the symbiosis, no longer identifying with their client's neediness nor with their client's idealized "good parent." The therapists began to enunciate their individual needs both to themselves and to their clients. If these two clients experienced the actions of their respective therapists as causing a break in the symbiotic tie, what effect did this "emotional abandonment" have on them? Were the therapists responding to some clues they weren't aware of that indicated some internal change in their clients? Or, by their actions, were the therapists motivating or forcing a change in their clients? What effect does it have on a client when the therapist pulls out of the symbiosis? Is countertransference a diagnostic as well as a therapeutic tool?

This event, i.e., the break in the symbiotic tie, is actually not a unique event. Rather, the break is a repetition within the therapeutic journey, of an earlier developmental occurrence. It is not an isolated, singular occurrence. Like adolescence, it is a reworking, a repetition of an earlier therapeutic experience. Specifically, it resembles the

break in the pathologic symbiosis which moved the client into the autistic phase of treatment. It is parallel to the therapist's pulling out of the pathologic symbiosis. In Example #1, I, as therapist, broke out of the pathologic symbiosis. I no longer felt I had to respond in certain stereotyped ways. I recognized how much pressure the client was exerting on me to so respond. The client was then "forced" to face the inner fragmentation and chaos, and the autistic phase of therapy began. Similarly, in the case of the break in the therapeutic symbiotic tie, the therapist no longer experiences the same depth of concern for the client. Searles (1965) described the freedom experienced as he fell out-of-love with his client:

> "In the sixth year of our work...I had become comparatively free from enmeshment in an ambivalently symbiotic relationship with her...I had come to feel, with predominant relief but with some guilt and concern, that I had 'fallen out-of-love with her'." (p.681)

Searles goes on to refer to his "sense of separateness from her which is so much greater than that of a few years ago." (p.681) Parallel experiences occur with breaks in the symbioses: In the first break the client is faced with autism, and in the second break he or she is faced with individuation. These states are similar. Searles (1979) noted:

> "The separation anxiety involved has less to do with the imminence of physical separation than with the imminent threat to both participants lest their lively symbiotic relatedness give away at any moment, unpredictably and uncontrollably, to autism or individuation (outcomes which do not seem differentiated in the patient's grasp of the situation, nor at all well differentiated in my own understanding in that context). Thus, the imminence of either

> outcome poses the same subjective threat to one's being torn asunder at any moment." (p.182)

At both points in the therapeutic process, impetus for change in the treatment relationship may come from the therapist responding to an internal shift towards greater neutrality.

These therapeutic events have traditionally been studied in terms of either the client's or the therapist's needs. Such a stance is exclusionary, and limits our understanding of the interaction. We can examine the interaction in terms of both and, that is, the needs of both the client and the therapist by applying Racker's conceptualizations. A very different line of thought is then suggested. For instance, in both Examples #5 and #6, through concordant identifications with the clients, the therapists had accurately assessed the clients' growing abilities to function as whole persons rather than as parts of another person. That is, the therapists unconsciously sensed the clients' readiness for greater clarification of the separation between the two of them. According to Racker's formulation, the therapists' unconscious awareness of the client's developing ego prompted the therapists' actions. This concept can allow one to answer the question raised by Searles (1965):

> "I know of no simple answer to the question which emerges from this discussion: namely, <u>when</u> is it therapeutic for the therapist to respond neutrally, and when non-neutrally? This is a question which is always before the therapist, and which can only be decided from moment to moment on the basis of his intuitive--i.e., primarily preconscious and unconscious, unthought-out-sensing of the patient's changing needs." (p.651)

The therapist's movements may be orchestrated by acute sensitivity to the client's needs which in turn may be known only through the therapist's countertransference identifications. These identifications parallel an empathic mother's sensitivity to the changing needs of her developing child, before the child's development of an ability to communicate verbally. It is likely that the pathologic symbiosis is given up by the therapist when he or she consciously (or unconsciously) recognizes that the client no longer needs the therapist to fulfill this function.

It is likely that my move toward a greater individuality and neutrality grew out of my identification with her ego which in turn felt stifled by her parent who could not allow her to separate. My anger and subsequent limit-setting in Example #6 symbolized my refusal to continue responding in a soothing manner without expecting the client to take responsibility for herself. My behavior was no longer appropriate. I knew, albeit subconsciously, that there was no longer the need for me to be so "sensitive" a figure. The client had developed her own capacities for tension reduction and self soothing. Often in psychotherapy, the "proof of the pudding is in the eating." That is, we can only evaluate an intervention after we see the results. In the case of the client in Example #6, my shift to a stance of greater neutrality was later understood by both of us to have been appropriate. The client dealt with the perceived rejection by getting a job and assuming more responsibility for herself than she had thought possible. Her hallucinations disappeared and her interpersonal functioning improved. At the present time, four years later, she is

self-supporting, working as the co-director of a child care center; she has a group of friends she sees regularly, and she continues to work in therapy.

My intervention was made out of a preconscious understanding of her growth and ability to tolerate greater separation. An understanding of Racker's countertransference model can enable a therapist to become aware, consciously, of such subtle shifts, and to intervene appropriately in a disciplined and systematic fashion.

The research sub-question this discussion addressed is: Can countertransference experiences be used to identify the extent to which a schizophrenic individual can differentiate self from other? Racker's theory that the therapist unconsciously and consciously responds both to the client's personality (id, ego and superego) and to the client's internal objects can be extended to understand that a change in the client's internal structure (or internal struggle) creates a corresponding change in the therapist's response. One can wonder who has a need for greater self-definition--client or therapist?

Searles (1979) found the question unanswerable:

> The symbiotic instability of ego boundaries makes it impossible to know whether the anger or depression, for instance, which one suddenly experiences is one's 'own,' or whether one is emphatically sensing a feeling of the patient's 'own' against which he is successfully defended unconsciously (as by projection)." (p.182)

It is likely that the timing of the therapist's need to emancipate from the therapeutic symbiosis is prompted by an identification with

the client's developing ego. It is this author's belief that the therapist unconsciously senses a change in the client. Were one to examine the interactions just preceding the events in each of these case examples (#5 and #6), one could perceive evidence of change in the client. Therefore, the therapist's actions can be understood to be a reaction to a change in the client and an indication that the client had begun to acquire the ability to differentiate self from other.

SUMMARY AND CONCLUSIONS

In this chapter, clinical material has been used to demonstrate the way in which a client's projections affect the therapist. The actions, awareness and experience of the therapist are influenced by the client's projections. The client's manner of relating to the therapist affect the therapist's self experience, especially when the manner is strikingly different from the usual way people relate to him or her. When a therapist monitors self experience in the treatment hour, that therapist also monitors the way in which he or she is related to by the client. That therapist is then monitoring how self experience is influenced by the introjections from the client. The experience of feeling "non-oneself" in a particular treatment situation can indicate that the client either misidentifies the therapist, or does not recognize him or her as a person to be related to.

Just as the therapist's self feelings may be influenced by the client, so the therapist's feelings about the client may be affected

by the client's projections. Material has been presented that indicated the therapist's need to break out of the therapeutic symbiosis. This "need" on the therapist's part resulted from an identification with the client's developing ego. The therapist acted out the client's need for more separateness in the relationship. Within this framework the therapist's reactions can be used to identify whether the schizophrenic individual has acquired the ability to differentiate self from other.

The main question is: Can countertransference be used to identify the emotional attitude of the schizophrenic client towards the therapist as well as detect changes occurring in that attitude? The clinical data and discussion demonstrated that the therapist's response to the client and therapist's self experience may well indicate the client's perception of the therapist. Whether the therapist is experienced by the client as "someone else," as "non-existent" or as a reality influences the therapist's self experiences in the treatment hour, and influences how the therapist responds to the client. Further, the client's capacity to experience the therapist as a separate person can be understood by the therapist's move to either symbiosis or distance from the client. As the client becomes capable of experiencing separateness from the therapist, the therapist no longer feels the need for symbiosis. In effect, the therapist responds to the client's most denied self. Therefore, if the definition of countertransference is broadened to include the therapist's self experience in the therapy situation, then countertransference can

and does provide information to indicate both the client's emotional attitude towards the therapist as well as changes occurring in that attitude.

CHAPTER 7

CONCLUSION

INTRODUCTION

This dissertation has been a theoretical and historical study of the phenomenon of countertransference. The overall purpose of this work has been to extend countertransference theory through a coalescence and extension of Searles' and Racker's work, and to suggest through case examples how countertransference can be used in the treatment process. An historical understanding was conceptualized an an important and basic facet of the investigation. Consequently, an historical review of countertransference through the literature has been included.

In its exploration of countertransference as a means of aiding treatment, this project was limited to one facet of the use of countertransference, viz., the use of countertransference specifically with individuals whose symptoms and behavior suggest a schizophrenic disorder.

FINDINGS

This study suggests that countertransference reactions can be used to formulate diagnostic information, to identify the client's emotional attitude towards the therapist, as well as to illuminate changes in that attitude. It is important to identify the emotional perspective of the client toward the therapist in order to understand the transference relationship, as well as to understand the needs of

the client at any particular moment. Clinical material has indicated the ways in which a client's projections affect a therapist and conversely, the ways in which the nature of the projections can be revealed by examining the therapist's responses and experiences. The examples used have illustrated first, the early phases of therapy in which the therapist may experience being misidentified or ignored by the client, and second, a latter phase of therapy during which the therapist may experience a new sense of separation from the client. This study contains six case examples, which show the validity of using the therapist's emotional experience to suggest information about the client when this experience is viewed as an identification. They also demonstrate that viewing the therapist's experience in terms of concordant and complementary identifications as described by Racker (1968), can facilitate a more profound understanding of both the client's self experiences and his or her attitude towards the therapist.

Further, this study has indicated that those feelings about him or herself experienced by the therapist within the therapeutic dyad can be useful treatment tools. This study indicates that the therapist's self experiences can be used to shed light onto the nature both of the client's self experience, and of the client's experience of the therapist. At times, it is only through the countertransference experience that the therapist is able to understand the client's internal perceptions.

There are two aspects to the countertransference experience. The first involves the therapist's feelings about the client. All of

the accepted definitions of countertransference, classical as well as totalist, define countertransference as the therapist's feelings or responses towards or about the client.

In the course of this study, a second aspect to countertransference was understood--one less written about and less discussed. Searles (1979) describes this aspect when he says:

> "As the months and years of the analyst's work with the autistic patient wear on, the analyst is given to feel unneeded, incompetent, useless, callous, and essentially non-human in relation to his so-troubled and beseeching and reproachful, but so persistently autistic patient." (pp.147-148)

This aspect of countertransference can be described as the therapist's feelings about the therapist which become evoked within the treatment dyad. One's feelings about oneself certainly affects the therapeutic interchange. Just as certainly, one's feelings can also give information about the client.

This study indicates that the definition of countertransference found in the literature is inadequate. There are two parts to the definition of countertransference: (1) The origin of the feelings, i.e., whether they are transferred from the therapist's past or a result of identification with the client; and (2) the object of the feelings. The Totalists, those who define countertransference as all of the therapist's feelings towards the client, are only Totalists with regard to the source or origin of countertransference feelings. They, in common with the traditional thinkers, refer only to the client as the object of countertransference feelings. This study suggests that the therapist's self-experience is also germane.

When the definition of countertransference includes both the therapist's responses towards the client and the therapist's self-experiences, then countertransference can illuminate the client's current emotional attitude towards the therapist as well as changes in this attitude.

SUGGESTIONS FOR FURTHER RESEARCH

This study suggests two additional areas for research. The first area focused on the client and poses several questions: Is countertransference a diagnostic tool with all types of pathology or only with pathology of psychotic proportions? Are some populations better understood by examining one's countertransference and others not? Are some countertransference experiences predictable and to be expected in the face of particular pathological problems, or at particular points in treatment? Is every experience with each new client unique or are there universal experiences most therapists will share?

The second idea focuses on the therapist and raises other questions. Do some therapists have a relatively easy time affectively understanding the client while others struggle to do so? If so, what are the factors involved? Can one learn to heighten one's awareness of countertransference experiences and if so, how? Can ways be found to differentiate countertransference experiences which result from the therapist's personal history, from those which result from an identification with the client?

IMPLICATIONS FOR CLINICAL SOCIAL WORK

"The social work method is the responsible, conscious, disciplined use of self in a relationship with an individual..." (Lurie, p.1029) Although the concept of use of self is a valued social work precept, this author has not found any literature which associates that precept with the method of observing and using one's countertransference experience. The only references found discussed how to identify one's own neurotic involvement in the therapeutic relationship. The definition of countertransference at the core of this dissertation is: Everything the therapist feels about the client and him or herself in the therapeutic relationship. The conscious use of self is the conscious use of one's countertransference experience. When countertransference is seen solely as neurotic, one's tendency is to try to suppress awareness of any countertransference reactions. This effort at suppression and selective inattention greatly inhibits the conscious use of self. An attitude of non-judgmental acceptance is essential to the treatment process--whether of the client's attitude or the therapist's feelings. This dissertation has demonstrated that neurotic countertransference is only one facet of countertransference. Completely separate from one's neurosis, countertransference identifications will be experienced by the therapist. These identifications give information about the client's self and internal objects. To ignore countertransference is to ignore oneself and the client. To attribute all countertransference to one's neurosis is to ignore the client's influence in the therapeutic dyad.

All treatment occurs within the relationship between therapist

and client. From its beginnings the field of social work has recognized the diagnostic and therapeutic importance of that relationship. Charlotte Towle directed the social worker as follows: "She should be able to allow a free development of the relationship with the client and be sensitive to the use that he is making of it." (In Perlman, 1969, p.49) This dissertation has focused upon the therapeutic relationship as the mileu in which the client and the therapist experience both themselves and each other. Following Towle's advice, this dissertation suggests a conceptual framework which can indicate the use the client is making of the therapist and of the relationship.

The population studied in this dissertation is considered "untreatable" by many therapists, particularly in terms of structural change. Such an assignation often results in a self-fulfilling prophecy, since "untreatable" is often used judgmentally. This author suggests the judgmental attitudes towards schizophrenic clients is based upon the therapist's lack of knowledge about the nature of a relationship for these individuals. For example, being grossly misidentified by a client does not mean that a relationship is impossible, rather it indicates that one is already the recipient of the client's projections and therefore is "in" the relationship. Social work has always viewed its mandate as "reaching-the-hard-to-reach" (Perlman, 1974, p.224), and assisting "deeply deprived, disorganized, disconnected people" (Perlman, 1974, p.224). In order to work effectively with these people we have to accept and utilize their impact on us, that is, our countertransference.

DISCUSSION OF THE FINDINGS

The term countertransference has been linked to the therapist's neurosis since Freud invented the word in 1910. Consequently, the term is tainted. Under ideal conditions its reputation might be wiped clean. We could start anew. We might also be able to accomplish that which has also not been possible, viz., the acceptance of another word to more adequately convey the interactional aspect of countertransference. This author prefers Sandler's term "role responsiveness," which highlights that part of the countertransference resulting from an identification with the client. However, since it is unlikely that either wish will be granted, the problem remains. How can we learn to use our countertransference experiences rather than to judge them? How can we make use of our experience for the benefit of the client? This study has demonstrated the possibilities of so using countertransference. Three main implications for clinical practice result from this study: (1) The use of the theoretical model of countertransference suggested in this paper offers a structured way to examine one's countertransference experience; (2) this model opens up possibilities previously ignored; and (3) the model enables one to accept countertransference reactions non-judgmentally, evaluate them, and then use them to enhance treatment.

CHAPTER 8

SUMMARY

In this study countertransference was examined first in its historical context and then as a treatment tool. The evolution of the concept was traced from 1910 to 1979 through a review of the relevant psychoanalytic literature. The literature revealed that, until recently, countertransference was utilized only to provide information into the therapist's inner experience. Gradually, writers recognized that a therapist can be influenced by a client's projections. One such writer was Racker, who also was one of the clearest exponents of a comprehensive view of countertransference. His concept viewed countertransference as deriving not only from the therapist's past, but from the therapist's identification with the client as well. Racker's theory was one of the theoretical bases for this study. An operational definition of countertransference was developed for use in this project. Countertransference was defined as the whole of the therapist's images, feelings and impulses about the client and about the therapist.

The purpose of this study was to explore countertransference as an avenue of information about the client and the client's internal objects. The question addressed in this study was: Can countertransference be used to identify the emotional attitude of the schizophrenic client toward the therapist as well as detect changes occurring in that attitude? Schizophrenia was defined and described, and an interpersonal psychodynamic treatment approach was elucidated.

The method of investigation was to view countertransference responses as identifications with the client or his internal objects to see if this enlightened the therapist about the client. This project demonstrated that countertransference responses can give information about a client's current emotional attitude as well as about the client's changes in attitude toward the therapist. Via the use of countertransference responses, the therapist can be provided with additional information about the client's experience, perception of the therapeutic relationship and about the therapist. With this information the therapist can more easily deal with the psychotic transference and "meet the client where he is" through a conscious use of one's self experience.

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