THE USE OF COUNTERTRANSFERENCE AS DIAGNOSTIC DATA IN THE TREATMENT OF NARCISSISTICALLY DISORDERED INDIVIDUALS

Elinor Dunn Grayer

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INSTITUTE FOR CLINICAL SOCIAL WORK

We hereby approve the Clinical Research Project

THE USE OF COUNTERTRANSFERENCE AS DIAGNOSTIC DATA
IN THE TREATMENT OF NARCISSISTICALLY DISORDERED INDIVIDUALS

by

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candidate for the degree of Doctor of Philosophy in Clinical Social Work.

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THE USE OF COUNTERTRANSFERENCE AS DIAGNOSTIC DATA IN THE TREATMENT OF NARCISSISTICALLY DISORDERED INDIVIDUALS

A Dissertation submitted to the
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ABSTRACT

THE USE OF COUNTERTRANSFERENCE AS DIAGNOSTIC DATA IN THE TREATMENT OF NARCISSISTICALLY DISORDERED INDIVIDUALS

This dissertation is a theoretical and historical study of the phenomenon of countertransference. The overall purpose of this work is to extend countertransference theory through a coalescence and extension of the works of Heinz Kohut and Heinrich Racker. The focus of this study is the diagnostic use of countertransference responses. Specifically, this study explores the use of countertransference to illuminate and help identify the self-object transferences that develop in the course of work with patients designated as Narcissistic Personality Disorders, as defined in the self-psychology theory of Heinz Kohut.

In order to make that exploration it is necessary to understand the concept of countertransference, its definitions and uses, its sources and the various theories regarding it. Thus an historical study of the evolution of thinking about countertransference is an integral aspect of the work. The evolution of the concept of countertransference is traced through a review of the literature from Freud's conceptualization in 1910 through the current

writers to 1979. Trends in patterns of perception, conception and interpretation are noted, and three major focal areas are identified.

Throughout the literature review, the work of Heinrich Racker emerges as original, thoughtful, integrative and remarkable. Racker's theory is highlighted, and a detailed review of his work included. The self-psychology theory of Heinz Kohut is similarly highlighted and a review of that theory is also included. Racker's theory is applied to parts of Kohut's self-psychology theory through the medium of case examples. Five cases are presented and discussed. The therapist's countertransference responses are revealed, as is the therapist's use of these responses.

This study develops an operational definition of countertransference which varies somewhat from established definitions.

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DEDICATION

This work is dedicated to

William Grayer

Friend, editor, mentor and cohesion-enhancing self-object.

ACKNOWLEDGMENTS

I want to acknowledge and thank those who, knowingly and unknowingly, contributed to this work

and

My patients, who patiently lived through my long bout of countertransference

My family who lived with countertransference for so long, who understood, read, commented and edited

The integrative committee (as it was then called) who read each draft, suggested, commented and critiqued, and finally

Patricia R. Sax, Ph.D., my friend and collaborator, for her capacity to think so clearly and originally, for her open generosity in sharing her talents with me, and especially for her willingness to patiently sit through my arguments and resistance.

My heartfelt thanks.

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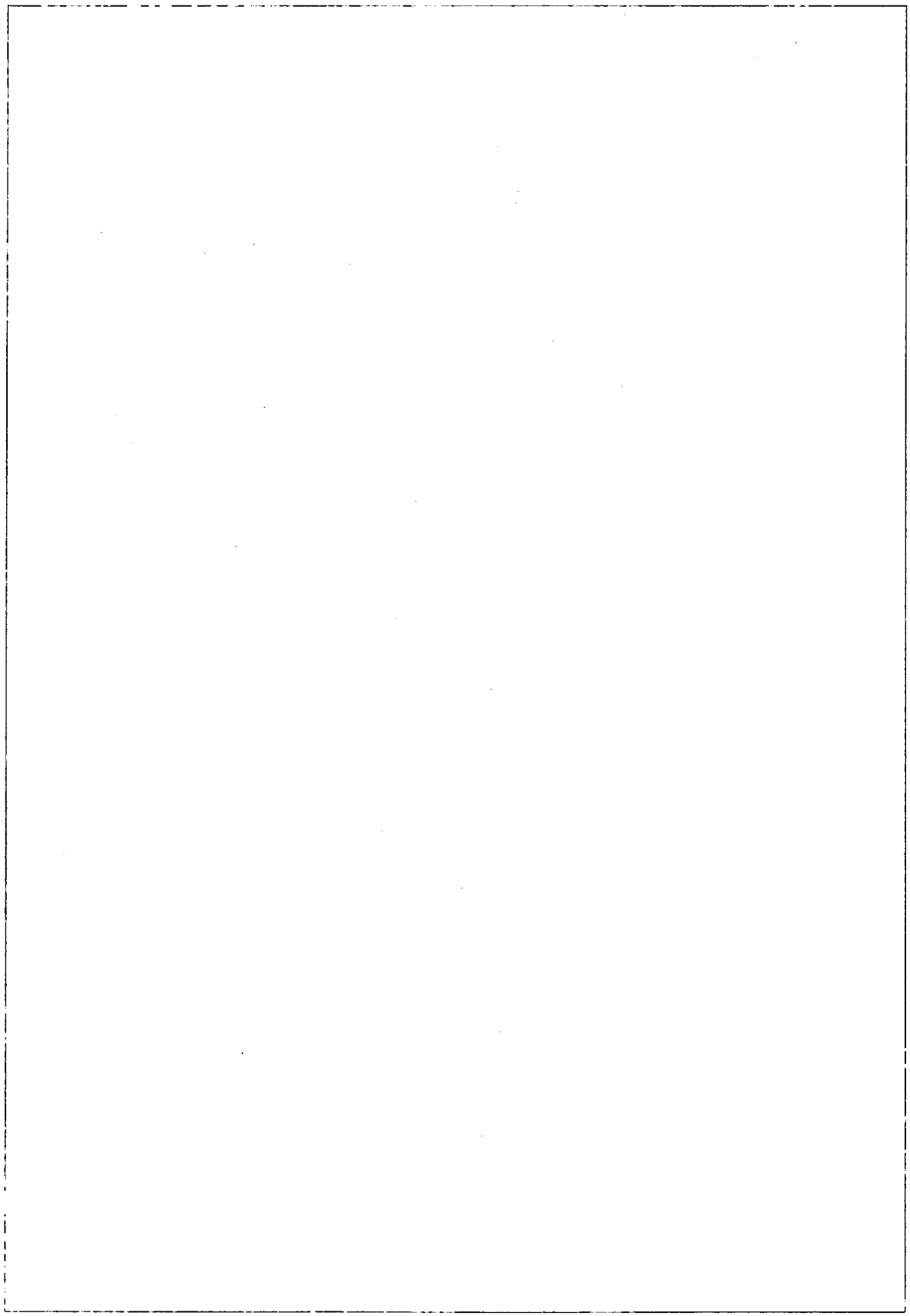

Chapter

CHAPTER 1

INTRODUCTION

> We have become aware of the "counter-transference" which arises in [the physician] as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize his countertransference in himself and overcome it (Freud, 1910).

Thus was the term "counter-transference" coined. It is curious that this concept of the analyst's response to the patient emerged only after almost a quarter century of work, especially so when the notion of the patient's response to the analyst began the entire process. It was in 1893 that Freud first named the patient's responses and feelings for the analyst "transference." The reciprocal concept, the natural concomitant emotional response to the patient, was neither conceptualized nor given a name for 17 years more. Curious and significant. In order for a relationship to exist, the reciprocal must have meaning. A duality must pertain.

From the first, psychoanalysis was perceived as a science; its proponents wanted it so seen because its detractors criticized it for its lack of scientific objectivity. Freud adhered to the assumption that to be valid, psychoanalysis had to be a science, and its practitioners,

scientists. They were to be objective, detached, removed observers, with observations uncolored by any interaction between the observer and the observed. So goes the myth. In this mythology, countertransference could not exist--it would have been an anathema to the belief in the scientific nature of psychoanalysis. Yet, exist it does, as surely as its more accepted counterpart--the transference. While the term is recognized by every student of every persuasion of psychotherapy, the concept has no single accepted definition as has the concept of transference. Further, there is no authoritative, accepted view of the source of countertransference nor of its function within the therapeutic relationship. The first and therefore core definition saw countertransference as the analyst's response to the patient's transference; a narrow and constricting view that inherently cast a pejorative light.

At present the term is used in a myriad of ways: to explain non-beneficial responses of the therapist to the patient, to account for therapeutic oversights, misdiagnoses, resistances, and also to describe empathic, potentially beneficial responses. Most recently this aspect of the psychotherapeutic interchange has been the focus of much professional attention, i.e., the therapist's response to the patient has become an accepted topic for investigation.

My own interest in this phenomenon is perhaps typical of the general current interest. It grew out of my countertransference reactions. My emotional responses to patients did not always fit neatly into the container of unresolved, intrapsychic conflicts. Some did, to be sure. However there were times when, as my patient talked, I would fantasize something unrelated to my personal experience. At other times, I would respond to a patient in a manner most unusual for me. At still other times, I would experience myself in an alien way during the session; that is, I did not feel about myself as I customarily do when at work. I could not account for these responses within any of my familiar frameworks.

I investigated my responses in various ways. I found that there was often a connection between my feelings and the way my patient felt, whether those feelings concerned me or him or herself. When I understood my countertransference reactions as deriving not so much from unresolved, drive-related conflicts as from an unconscious wish, command or demand of my patient, I was able to use my reactions in a diagnostic manner.

This project is the result of those beginning attempts to broaden my view of countertransference phenomena. It has been written in collaboration with Patricia R. Sax, Ph.D. Her dissertation is also a study of the diagnostic use of countertransference and focuses on the use of these

reactions with psychotic 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; 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 our patients. The reader is therefore referred to the work of Dr. Sax for a study of the use of countertransference responses with psychotics. The two studies taken together cover a wide range of pathological conditions. Chapters 3 and 4 were collaboratively written, and are identical in each work.

The focus of this study is the diagnostic use of countertransference responses. Specifically, this study explores the use of countertransference to illuminate and to help identify the self-object transferences that develop in the course of work with patients designated as narcissistic personality disorders.

In order to make that exploration it is necessary to understand the concept of countertransference, its definitions and uses, its sources, and the various theories regarding it. Thus a rather detailed study of the

evolution of the concept as shown through the literature is also a part of this project.

Throughout the literature study, 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 understanding of the theoreticians who preceded him. Racker's theory is highlighted, and a detailed review of his work is included. This study then applies Racker's model to selected facets of the self-psychology theory of Heinz Kohut using the medium of case examples. Five cases are presented and discussed. In these examples, the therapist's countertransference responses are revealed, as is the therapist's use of these responses to facilitate an understanding of the client and of the interaction between therapist and client. The process of using countertransference responses to illuminate a patient's dynamics is demonstrated and explained.

The literature also reveals that a number of definitions of countertransference exist but that no universally accepted one has yet to emerge. Accordingly, this study develops an operational definition of countertransference.

The conclusions and results of this work do not prove the universal value of countertranference reactions in a clinical setting. Some therapists have found and will continue to find real value in the examination of their countertransference feelings, and in the use of them as diagnostic clues; others have rejected and will continue to reject the idea of value in the countertransference phenomenon. But if universality cannot be expected, I hope that this dissertation will help many clinicians to realize the potential inherent in recognizing their responses in the therapeutic setting and in using them in a positive way.

CHAPTER 2

THE STUDY: ITS PURPOSE, QUESTION, ASSUMPTIONS, DEFINITIONS, LOGISTICS AND LIMITATIONS

Purpose

The purpose of this project is twofold: (1) to explore the use of countertransference as diagnostic data. The possibility of so using it was hinted at in the early writings about countertransference, yet never fully developed. Specifically, this study undertakes to develop a way of understanding countertransference reactions that will enable the clinician to deal more effectively with narcissistically disordered individuals. This pathological state is inordinately trying to the clinician. Kohut has been quoted[1] as recommending that an analyst have no more than two or three narcissistically disordered patients at any one time, because of the intensity of the narcissistically disordered person's relationship with the therapist. Therefore, it is hoped that this study will enable the clinician better to understand the countertransference vicissitudes of working with these patients; that is, have

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[1]Conversation with J. Palombo, M.A., formerly of the Chicago Psychoanalytic Institute, 1979.

a framework within which to understand the various elements of the transference. (2) It is also the purpose of this work to study the evolution of the concept of countertransference using the literature as a medium. This portrayal is intended to facilitate the exploration of a new way of understanding the phenomenon.

Question

The basic question this project addresses is:

> Can countertransference reactions be used to verify the existence and specific nature of the pathology in an individual believed to exhibit a narcissistic personality disorder as defined in the self-psychology theory of Heinz Kohut?

The sub-question that grows out of this main question is:

> Can countertransference reactions be used to help identify the self-object transference as defined in self-psychology?

Assumptions

Two basic assumptions are intrinsic to the study:

1. It is assumed that the therapist's countertransference is to some degree knowable, i.e., that the countertransference experience is conscious and preconscious, as well as unconscious.

2. It is assumed that like transference, countertransference is always present to some degree.

Definitions

For this study, countertransference is defined as all of the therapist's responses to the patient. This includes all of the therapist's responses--conscious and unconscious, feelings and associations, thoughts and fantasies--to the patient, to the patient's material and affects, and to the interaction between them.

As is seen in the body of this study, this definition is close to Racker's and also to the definitions formulated by other theorists. The others, however, define countertransference in terms of the therapist's (analyst's) feelings about the client (patient). As this study evolved, it became clear that many of the feelings described as countertransference responses were actually feelings of the therapist about the therapist--that is they described the therapist's "self-feelings" (I feel bored, angry, sleepy), not only the therapist's feelings about the patient (he is difficult, she is a clinger, he is a delightful man). Therefore, the definition combines both the therapist's feelings about the patient as well as the therapist's feelings about him or herself. Both are considered to be countertransference, and the study demonstrates the use of both sets of feelings to give diagnostic information about the patient.

This investigation is limited to a particular patient population: those individuals who in self-psychology

parlance are designated narcissistic personality disorders. Since self-psychology is still relatively new, one chapter has been devoted to an explanation of its theory and particularly to the development of the pathognomonic transferences which develop. Self-psychology theory was named and developed by Heinz Kohut of the Chicago Institute of Psychoanalysis. Kohut's theory of narcissism, which resulted in his self-psychology theory, began to appear in the literature in 1958.

Logistics of the Project

Chapter 3 is an historical study of the evolution of the concept of countertransference through a review of the literature. The literature is reviewed chronologically to develop a sense for the way the concept evolved through the years. A major reason for this choice of structuring the literature review grows out of my personal experience with countertransference responses. I found that my experience as a therapist paralleled the development and evolution of the concept as seen through the literature: I first became aware of disquieting feelings toward my patients, feelings of love and hate, anger and boredom, involvement and withdrawal. At times, I experienced shame over those feelings, telling myself I had no right to such subjectivity. I implored my professional responsibility to my patients. Further recognition and exploration

resulted in a grudging acknowledgment that I too could respond non-rationally at times. Gradually the combination of experience and a growing sense of competence resulted in a more non-judgmental acceptance of my countertransference experiences. With that acceptance came the ability to explore my responses in the context of the relationship that I shared with my client. In Chapter 3, the concept of countertransference is examined as it went through similar phases, paralleling the growth and maturation of this profession devoted to psychotherapy. Chapters 4 and 5 contain the theoretical bases for this study.

Chapter 4 describes Heinrich Racker's theory of countertransference. The description is detailed and covers his entire theory. A diagram of Racker's conceptualization, developed by Patricia R. Sax, Ph.D., is used in this chapter to illustrate the model described.

Chapter 5 describes Heinz Kohut's theory of narcissism, the theory called self-psychology. The description does not cover all of Kohut's theory--to do so would have been cumbersome and beyond the needs of this project. The chapter focuses on the piece of Kohut's theory that describes the unique and pathognomonic transferences that develop in the course of psychotherapy with individuals designated narcissistic personality disorders. Those transferences are entitled "self-object transferences."

It is through the transference relationship that one can best diagnose this malady. It was found that the countertransference responses parallel the developing transference and thus are also pathognomonic. Kohut's theory of narcissistic development is depicted in a diagram which I developed, but which was based on one developed by Joseph Palombo, M.A. (Chicago).

Chapter 6 is entitled, "An Integrated, Clinical Application of Heinrich Racker's Theory of Countertransference and Heinz Kohut's Self-Psychology Theory." This chapter addresses the basic questions posed in the beginning of this chapter. It contains the theoretical work of the study. Five case examples are used to demonstrate the diagnostic use of countertransference. Of these, four were drawn from my own clinical material, while one was contributed by a colleague who courageously shared her countertransference feelings and responses to them, as well as a description of what she actually did with them. An interesting event occurred in connection with this contribution, one which itself demonstrates the ability to use countertransference as a diagnostic aid. My initial request to my colleague and friend came at a time when she was rushed. She told me briefly of her countertransference reactions, describing her affects without telling me much of her patient. Her voice over the telephone was appropriate to

the affects she described. Several days elapsed before we had a chance to resume our conversation and during that time I speculated about my colleague's patient. I speculated about her appearance, relationships, and affects. I formulated a diagnostic impression, guessing this patient to suffer a narcissistic disorder. I further guessed that this patient's major deficit was in the area of the grandiose self. I described that speculated-about person to my colleague. To her surprise my speculations were remarkably accurate, in that they conformed to my colleague's diagnostic impressions. Even my guesses about the patient's physical appearance were accurate.

Chapter 7 concludes this study with a brief summary and a discussion of the findings. The implications for clinical social work are discussed.

The results of this study suggest that countertransference reactions can be used diagnostically, to give the therapist information about the patient, the patient's internal objects, and the relationship between patient and therapist. The results of this study should enable the clinician better to understand the countertransference vicissitudes of working with narcissistically damaged individuals and to have a framework within which to understand the various elements of the countertransference. That understanding can enable a clinician to sustain

countertransference feelings rather than discharging them, to understand them as the response to a process in the patient and in turn, to discover the source of those responses. As Issacharoff (1979) so aptly wrote, "Countertransference is the living response to the patient's emotional situation at a given moment" (p. 30).

Following the bibliography, an appendix has been added, listing those references specifically pertaining to narcissism and self-psychology.

Limitations

This project is a theoretical work. It extends the limits of existing theory beyond its present use. It combines two current theories (Racker's countertransference and Kohut's theory of narcissism). This study's contribution is to combine and extend their theories, and to demonstrate the application of the results through the illustrated case material.

This is an 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. Although this study is not based on an experimental model, one of the five case applications came from an outside source, and in that instance the author was able to diagnose, fairly accurately, the patient's

pathology using the therapist's countertransference feelings as data. That instance is suggestive. It may serve as a model for further studies, should a future scholar choose to pursue this investigation in an experimental fashion.

As indicated earlier in this chapter, this study grew out of this author's clinical experience. More accurately, it represents an effort to understand and systematize clinical experience. The basic theory, which led to the questions posed in this chapter, 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.

CHAPTER 3

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

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.[2] In addition, the words "analyst" and "psychoanalytic treatment" were used as search words.

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[2]Chicago Psychoanalytic Index, Index Medicus, Psychological Abstracts, Science Citation Index.

The bibliography comprises 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 fascinating. For example, few articles were published in the early years. The first post-Freud reference was written in 1919 by Sandor Ferenczi. From then until 1949, only 19 references to countertransference were found.

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

Thus, the first 38 years (1910-1948) following Freud's identification of the countertransference concept, which produced only 19 pieces of literature devoted to it, resulted in an average of only one every other year. By contrast, the next 30 years produced 182 references, about six per year--an increase in the annual yield of more than 10 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.[3] 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.

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.

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[3] International Journal of Group Psychotherapy, October 1953, Vol. 3, No. 4.

Transference is relatively easy to consider. Basically, it grows out of the patient's internal perceptions. It is experienced by the patient 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 the 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 <u>science</u>, 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 would its revelation.

In addition, much of the earliest writing pointed to countertransference as an expression of either the therapist's unresolved narcissistic needs or as an expression of the male therapist's libidinal urges towards a 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 non-rationally to a patient, even when provoked by the onslaught of the patient'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 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" (pp. 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 self-analysis and continually carry it deeper while observing patients. 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" (pp. 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 unconscious to gain an understanding of the patient's unconscious. Here, then, is a hint that the therapist's responses to the patient are a part of the therapeutic interaction and 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 (1957), Freud (in 1913) 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--love and by implication hate--for the patient; 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 of oneself 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, capable of rising above one's responses, capable of a psychoanalytic purification, and thus capable 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 patient'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, at least in part. He cautioned that the therapist must learn to control his affects,[4] 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

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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.

discussed, and to some extent clarified, the difference between resistance to the countertransference and control of it. This notion--resistance to countertransference--reemerges 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 patients--those whom we would today label psychotic. He took these patients into his home, so that his involvement with them became more intense 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 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 even 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 patient'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 patient'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 patient'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 patient and therapist, and that the countertransference grows from that relationship. Consequently, concerning the patient'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 patient. The predominant thinking said these feelings could only be a hindrance. Not so, said Ferenczi; this 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 patient; he saw the importance of the interactional process and he accepted the idea that the therapist and patient unconsciously influenced each other.

Despite Ferenczi's view, countertransference was to continue for some years to be the black sheep of the psycho-analytic 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 patient 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 patient'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 comfortable 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 patient's difficulty with libidinal urges for the therapist, and that the countertransference is probably fraught with just as much shame.

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 patient'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

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[5]In common with many of the early writers, Stern's language reflects no awareness of the existence of female therapists. He addressed only the issue of male therapists and female patients. 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-à-vis her male patients.

is an image for the patient, and that the patient'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 patient's adoration but to recognize the flattery as derived from the patient's fantasy life.

The second sphere of countertransference involves the therapist's anxiety in the face of the patient'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 patient's unconsciously determined activity as if it were consciously determined and occurring in the present; that is, misunderstanding the patient'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 human frailty can and will be eliminated. In his discussion, 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 what might be called professional perfection; i.e., 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 have only recently reemerged 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 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 nonrational 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 Helene 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 republished 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 patient and therapist; that the patient's urges derive from the transference, while the therapist's come from an identification with the patient. According to Deutsch, the therapist's ability to form this identification with the patient 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 patient tends to direct ungratified infantile wishes towards the therapist. The therapist then becomes identified 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 Heinrich 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, could now be 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 Psycholoanalysis" (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 were defined as reactions to the patient's transference manifestations; i.e., the therapist's transference responses to the patient's transferences. Glover devoted much of his lectures to identifying techniques for recognizing countertransference and counterresistance, although his definition of each was less than totally clear. Rather than reaching an abstract

definition, Glover described counterresistance anecdotally. He seemed to be saying that its development is provoked by countertransference and parallels the patient'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 Baillière, 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 counter-resistances 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 Baillière, 1955) suggested using countertransference feelings or difficulties in the same way to assess the therapist's conflicts:

> . . . the commonest source of counter-resistance 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 counter-resistance] 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 (Baillière, 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, 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 patient'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 patient to be based upon countertransference problems, i.e., the therapist's problems, and she prescribed analysis for the therapist. She saw countertransference as an unavoidable reflection of the therapist's unresolved transferences, and felt that if the therapist's countertransference could be brought into a suitable equilibrium with the patient's transference, then countertransference could acutally facilitate therapeutic work. In a vague, and poorly defined way, Hann-Kende was one of the first writers to allude to the possible constructive 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 seem to have gone unnoticed. They saw countertransference as everything the therapist feels toward a patient. " . . . 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 patient, not just to intraphysic conflicts evoked by the patient's transference. There was no discussion of these implications, which seem to have been made casually, without awareness of their impact.

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

patient'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 responsiblity onto the therapist:

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

The time had not yet come to democratize the therapist-patient relationship.

The time had come, however, to challenge the faith placed in the ideal of the "sterile" method of therapy, 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 points out that the therapist creates an impression on the patient 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 patient'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 Balints' 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 patient. Fleiss termed this empathy "trial identification" (pp. 212-213).

He said that each and every one of the patient's neurotic conflicts must be translated into a transference conflict and that the patient'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 (counter-transference) 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 patient 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 provies the first and least defensive exploration into the therapist's experiences, roles and attitudes.

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!" [matzo 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 (pp. 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 underscores 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 person's impulse as such, but its unconscious echo in the ego 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 patients, was born of thorough self-analysis. The book

was a significant landmark in the history of the literature on countertransference. 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.

Although Reik's work is probably the first intimate view of the therapist's reaction (i.e., the 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.

During these years, some authors began to consider the nature and composition of the phenomenon, i.e., 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 counter-transference 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 counter-transference. It is its nature that matters. We can hardly hope to carry on an analysis unless our own counter-transference 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 patient as if the patient 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 patient. Reik, focusing upon the therapist's experience, wrote of the therapist's feelings as a road to the patient's unconscious.

Berman, on the other hand, wrote of the therapist's process as a model for the patient's development, deemphasizing the therapist's experience, and focusing on the impact of the therapist upon the patient. 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 toward the patient, 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 patient 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.

> 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 (pp. 69-70).

Winnicott basically referred to work with psychotic patients. However, his discussion describes some ways in which the therapist can manage hatred towards the neurotic

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

patient. 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 patient, 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 patients are not only normal and proper, but useful; useful as a modeling experience and useful as an opportunity for the patient to work through complementary feelings aroused by the therapist's countertransference. The function of the countertransference had been alluded to by other authors (Deutsch, 1926; Fleiss, 1952; 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 patient, and the usefulness of such hateful feelings implied an acceptance that allowed for new ways of thinking. Or perhaps the time was ripe 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. 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 patient 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, Heimann, 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 countertransference 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. (As with 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 experience 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 patients.

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 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 patient; she then considered the possibility that the therapist's countertransference is created by the patient. She suggested that the term "counter" goes beyond the transference reactions of the therapist to become a counterpart of the patient'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 patient'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 relationsip 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 patient'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 creation, 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 toward the patient 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 patient: the patient'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 patient'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 patients, Little recommended that the therapist admit an error to the patient 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 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 patient.

Little's first two articles were written six years apart and together comprise 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), Fleiss (1953), and Sandler (1976). They will be discussed in a following section of this review.

In the earliest of her 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 counter-transference 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, trasnference 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 patients: 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 communicate 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 the 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 patient and the patient 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 Feiner and Epstein (1979) elaborated Little's views, and recommended that therapists selectively communicate induced feelings to schizophrenic and borderline patients. 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 Henrich 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 patient. 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 of his understanding or technique. In such cases the patient represents for the analyst an object of the past onto 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 object 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 harnessed 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 patient. 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 patient 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 patient's anxiety to the therapist.

She recognized, as did Winnicott, that the therapist is emotionally affected by the patient, i.e., that Annie Reich's uninvolved therapist is a myth. Thus, with the exception of Reich's writings which represent 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 origins 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;
3. The author's attitude towards countertransference as a phenomenon, i.e., whether a detriment or an aid.

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 held by the majority of post-1950 writers 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-à-vis the patient. 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 analysis 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 patient. 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 counter-transference 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 patient'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 counter-transference. 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 counter-transference 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, by 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 particular patients; 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 tool (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 definition of countertransference understands it ". . . 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 solution 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 patient. The article points out that the modernist view gives the therapist permission to accept and utilize subjective reactions to the patient. Discussing the therapist's responses, he 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 soufflé 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 counterresistance 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 agent--the aspect which Searles referred to as an empathic experiencing of feelings emanating from the patient, 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 "palintropy" or "palintropic processes." He felt that term would allow the inclusion of all the processes occurring between two people. He liked the term. It literally suggested to him a going back and forth between patient and therapist and does not start with the patient, 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 patient, and ideally can be managed by the therapist. It does not have to exist. Palintropy, 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 patient and from the interrelationship between the two people. These were two different kinds of countertransference 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 patient. 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 patient. He suggested the term "diatrophic," which in his description seems to be equivalent to what might be called a parental attitude or identification towards the patient.

> 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 definitions of countertransference as either the analyst's unconscious reactions to the patient's transference, or the analyst's unconscious transference to the patient. Some of these terms are: "counter-resistance" (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 a 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 patient and to the therapist, attributing to it the therapist's ability to sustain the patient'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 patient. Each concluded that the therapist's awareness of and attention to the real relationship makes it possible for the patient 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 patient 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 patient 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 countertransference 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 necessary 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 patient's helplessness in the analytic setting provides 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). Sptiz believed that this act of parental identification forms the seed of the countertransference.

Money-Kyrle (1956) credited the therapist's partial identification with the patient 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 patient represents an ill-resolved 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 patient.

Bryce Boyar (1979) took it for granted that introjection is the chief mechanism of countertransference. In an unpublished paper, he accounted for the therapist's increased countertransferential involvement with regressed patients by explaining that ". . . the combination of the regressed patient's tendency to use defenses which involve projection and the introjective aspects of countertransference 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 (1977) 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 patient'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 patient, i.e., repression. Later writers discussed mechanisms which attended more to the interactional process and the real effect of the patient on the therapist which was accentuated by the therapist's wish to be open to experiencing the patient. 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 patient, 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 constantly must 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; 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 and Kapp (1962). Still others see countertransference as a key to the patient'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 the 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 patient, overemotional responses, unreasonable like or dislike for the patient, drowsiness, arguing, defensiveness, etc. These responses, taken as signals, can clue the therapist to the existence of a countertransference reaction although it must be specifically identified.

Rosenfeld (1964) discusses the use of the therapist's countertransference in work with psychotic patients:

> 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 patient will evoke difficulties already existent in the therapist, while other authors believed that the patient'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--that the difficulties do not rest with the therapist but are inherent to the patient'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 patient'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 patient.

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 patients, and believe that it is important to reveal in order to maintain a sense of reality for the patient, who has difficulty sorting reality out anyway. Not revealing, in this instance, can intensify the patient's confusion. The opponents believe that revelation is an indulgence, and places too great a burden on the patient. 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 patient

when appropriate for the purpose of strengthening the patient's reality-testing functions.

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 has an attitude towards 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 toward 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 patient'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 reviewed.

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 (1954) identified countertransference as the factor involved in a social worker's irrational like or dislike for a client. Some, like Pearlman, said nothing. Here and there, articles were published in social work journals regarding difficult treatment populations (Lieberman & Gottesfeld, 1973). Others wrote at length of transference (Sterba, Lyndon & Katz, 1948; Levey, 1940) 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.

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 which follows, 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 (p. 3).

His conceptualization of countertransference enables the therapist to distinguish a number of interactive and intrapsychic processes that are subsumed under this umbrella-like term. Racker (1968) suggested using the term countertransference generically and broadly, as an analog 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 meanings in patient-therapist transactions and formulated interpretations based on the understanding that developed. He identified a complex of normal predispositions shared by analysts and said that any of them could, under certain conditions, find themselves in the emotional position of a child vis-à-vis a patient-parent. This complex was termed the countertransference neurosis and was understood as being as natural and normal a phenomenon in the analyst as is the transference neurosis in the patient.

> 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, pp. 136-137).

Racker rejected the classical position that any strong emotion in the analyst, in response to a patient, is an aberration and signifies pathology within the analyst. He rejected also the classical concept that the analyst's normal ego state should be hovering, contemplative and neutral. Instead, his thesis was that the analyst's emotional state is at all times determined by the patient, and is in effect a creation of the patient. The patient 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 patient is doing. For instance, the therapist's detachment might be a withdrawal from a patient 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 patient'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 analyst is both the interpreter and the object of the patient's unconscious processes.

As interpreter, the analyst'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 analyst 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 analyst use 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 that which is transferred. 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.

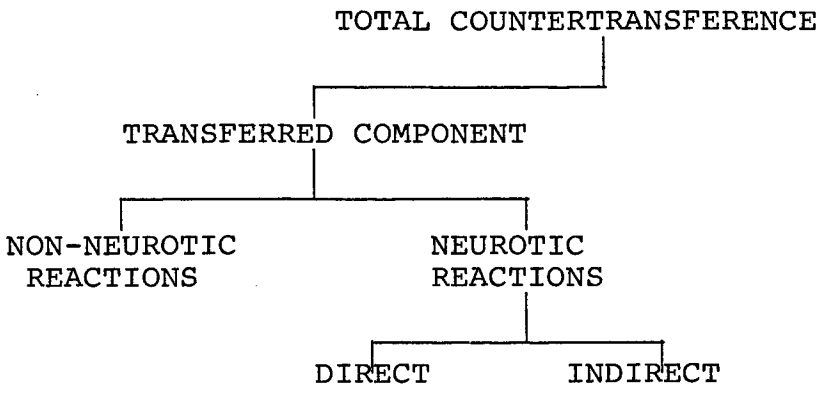
> Although the neurotic reactions of counter-transference may be sporadic, the predisposition to them is continuous (p. 111).
>
> The transference is always present and always reveals its presence. Likewise counter-transference is always present and always reveals its presence, although, as in the case 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 patient as the object of the neurotic transference. That is to say, the patient becomes the object of the therapist's neurotic transference--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 patient 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 to total countertransference is the one more fully developed by Racker. He, as had Helene Deutsch (1926) among others, recognized that certain processes of identification take place within the analyst in the therapeutic interchange, and that these identifications influence the analyst'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. 214). As he identified these processes, Racker returned to Deutsch's formulation, borrowed her terminology, built 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 patient's. This condition is similar to that described by Weigert (1951) as "empathic identification" (p. 473). For example, the therapist who feels pain for and with a client relating a pain-filled memory, experiences concordant identification. Racker (1968) described 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 analyst 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 understood concordant identifications as the basis of the therapist's empathy, and carefully built 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 patient's thoughts and feelings, as if the therapist's feelings run alongside the patient's. Concordant identifications can give the therapist information about the patient's self-experience.

Complementary identifications occur when the therapist's feelings complement or form a counterpart to the patient's feelings. They occur in session when the patient 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 patient had projected his image of a childhood figure onto the therapist with such intensity that the therapist accepts the projection and acts accordingly. The therapist now no longer understands that patient from the inside but instead, seems to be outside the patient, reacting in ways similar to the ways in which the original object reacted. For example, a needy and hungry patient can become so whiny and clingy that the therapist may respond as did the patient's parent. The therapist may feel empathic with the patient's rejecting parent rather than with the ignored child. In this instance, the therapist's response complements the

patient's behavior. The patient 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

> . . . produced 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 (pp. 134-135).

Because the therapist feels treated as, and partially identifies with an internal object of the patient, psychological processes in the therapist result in the patient'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).

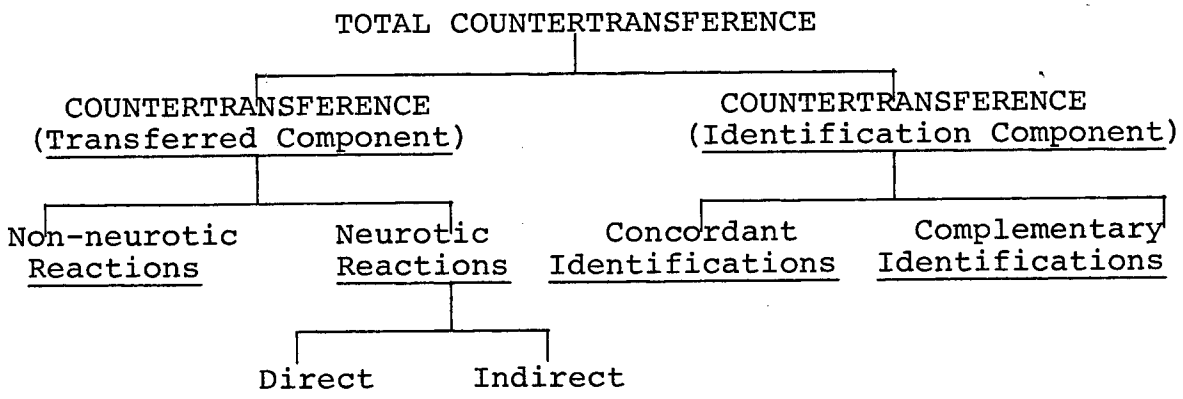
describes a complementary identification. Another example can be found in Ferenczi's (1930) concern for being a "good object."

In any one interview, 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 patient is communicating. At other moments, the therapist may respond as if he or she were indeed the object of the patient's projections.

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

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 frequently, 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 is a familiar one: he described the anger the analyst experiences as a result of the patient'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, and shared that 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 patient's processes. The following example illustrates a complementary countertransference position.

> Randi 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 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 patient's immediate awareness, the thought, feeling, or impulse expressed in the therapist's thought is one to which the patient 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 patient's acting out. The patient disowns his impulse, affect, or internal object and projects it onto the therapist. The therapist then unconsciously internalizes the projected object and feels like responding according to the patient's 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 upon the individual's neuroses, 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 patients can be important diagnostic information.

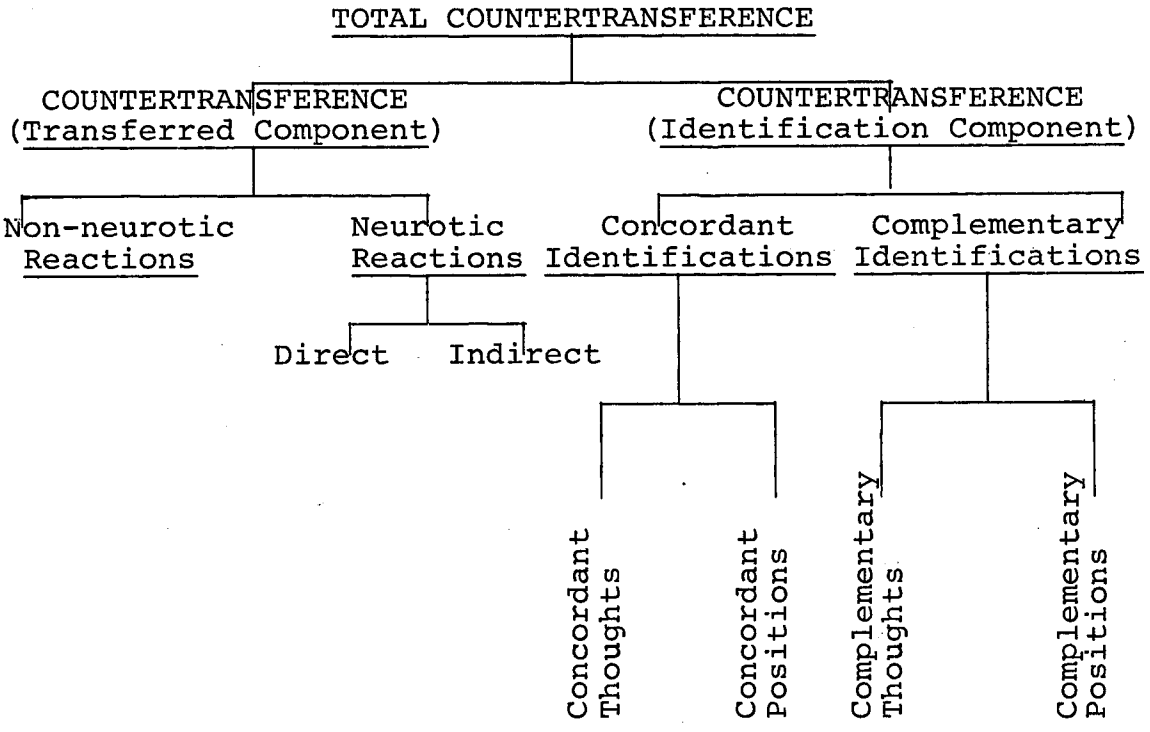
Otto Kernberg (1975) recognized this phenomenon:

> 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 (pp. 54-55).

This intense emotional reaction can be anticipated, using Racker's model, inasmuch as this patient suffers 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 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 the therapist's image, feelings, and impulses towards the client. In part these are determined by the therapist's past relations especially those relations with significant others,

and, in part, determined by the therapist's realistic and neurotic needs. Additionally, countertransference is determined by the therapist's identifications with the patient's internal objects, id, ego and superego, that is, the patient's personality.

A schematic representation of this formulation was developed, and included. This review has been written in order to establish the theoretical framework used in this study.

CHAPTER 5

THE SELF PSYCHOLOGY THEORY OF HEINZ KOHUT

This chapter is an overview of the self psychology theory of Heinz Kohut. It continues the outline of the theoretical framework beginning in Chapter 4, and is designed to further facilitate an understanding of self psychology theory and to complete the theoretical framework upon which Chapter 6 is based.

Introduction

Heinz Kohut is a psychoanalyst affiliated with the Chicago Psychoanalytic Institute. He was born in 1913 in Vienna, which he left in 1938 to emigrate to the United States. Kohut's first publication appeared in 1950; his theory of narcissism, which resulted in his self psychology theory, began to appear in the literature in 1958. He developed a psychoanalytic approach to the understanding of individuals considered unanalyzable by classical Freudian analysts. Kohut's ability to analyze this population successfully was based upon a precept which he entitled empathic observation, and which formed the

nucleus around which the theory called self psychology was developed. Self psychology's conception can be found in Kohut's article, "Introspection, Empathy and Psychoanalysis" (1959), and it is more completely described in The Analysis of the Self (Kohut, 1971). Self psychology theory is still in the process of evolution. It is being developed, as Kohut remarked, out of the empiric observations and practice of clinicians in the field. Consequently, much of the theory is yet incomplete and still suffers a lack of clarity. Its treatment approach centers on the use of certain unique transferences that develop during the course of psychotherapeutic work with individuals suffering deficits of the self.

Outline of the Theory

Kohut's self psychology theory is concerned with narcissistic development, and is at variance with the other major analytic theories. He views narcissism as a normal and necessary part of human development. In Kohut's view, it is not a defensive withdrawal of libidinal cathexis nor is it pathological.

Freudian psychology (still the predominant basic analytic theory) is essentially a drive and conflict psychology; i.e., a psychology that sees anxiety and pathology deriving from the conflict that occurs between

one's drives and one's socialization requirements. Kohut's psychology does not deal with drives and conflicts. Rather, his self psychology sees us as ultimately developing into a whole--a complete round pie as it were--a cohesive self. Kohut believes that pathology is the result of deficits, or missing pieces, in this circle of self. To Kohut, aggression is not a drive but a reaction to an injury to the self. The philosophical difference is a profound one. It is analogous to the religio-philosophical argument over whether evil is reactive or inherent. If aggression is not a basic drive but is reactive to injury, then the implication is that one must focus on the etiology of the aggressive impulses, understand the genetic roots and attempt to repair the injury. This is a basic concept in self psychology theory. The self is at the core of the personality, and ideally is a whole. When deficits occur in the development of the self, the personality is incomplete. The incomplete individual uses an intense attachment to another person to fill in the gap--to fulfill the functions of that missing piece of the whole. That attachment functions as a tie from the functioning individual to the incomplete one. So long as the tie is intact, the deficient self experiences wholeness. However, when the tie is ruptured, the sense of completeness and the individual's narcissistic equilibrium are shattered, and rage

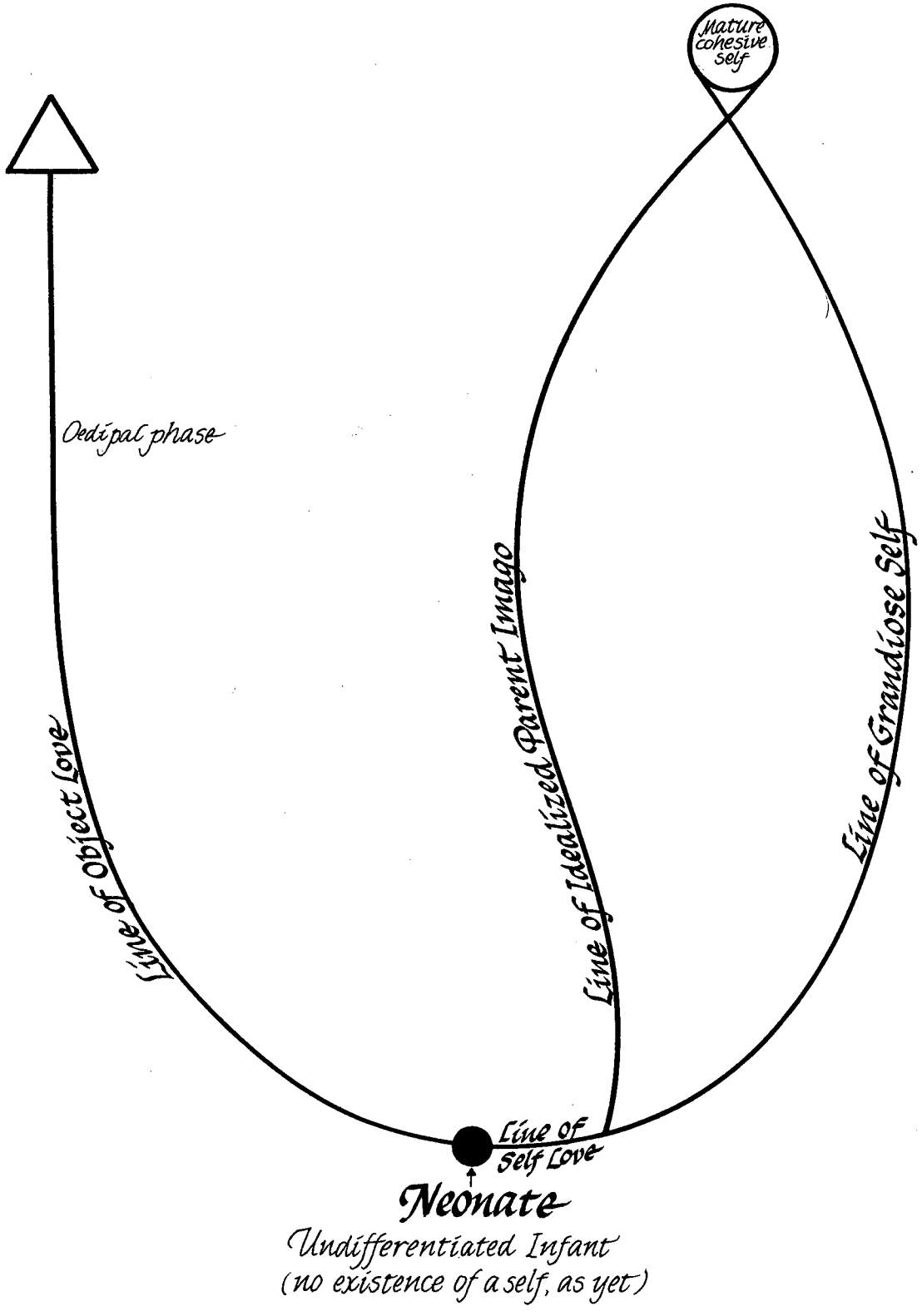
and fragmentation can occur. If the tie is repaired, not only can cohesion recur, but the reparation process itself can strengthen and solidify the personality.

Kohut has a concise way of summarizing the difference between Freudian and self psychology; the former is the psychology of guilty man, the latter the psychology of tragic man.

Dual Axis Theory of Development

Kohut posits a dual axis theory of development--in contrast to Freud's single axis one. One axis, the line of object love, is the same as that in Freudian theory; it proceeds through the oral, anal and oedipal phases to result in object love. The second, the line of self love (or narcissism) is bifurcate; each line represents a different constituent of the self with its own narcissistic development. Together they result in the development of a mature, cohesive self. The two major constituents are entitled the grandiose self and the idealized parent imago. The diagram on the following page outlines the developmental scheme. Each constituent has its own developmental sequence, progresses in its own fashion and is one of the lines of narcissistic development. Kohut theorizes that development along each axis proceeds independently of the

Development of the Mature Cohesive Self 1.



other, as does development along each fork (or line) of the self love axis.[7]

Kohut does not discuss development along the object love axis other than to say that each axis develops independently of the other and that both axes start with an infant who cannot yet differentiate self from non-self. The neonate is understood to be without a self. Though Kohut's theory does not pinpoint the age at which a baby may be said to have acquired a self, just as physiological survival requires a specific physical environment, so psychic survival requires a specific psychological environment. According to Kohut (1978), the sine qua non of psychological survival is the presence of responsive-empathic objects:

> It is in the matrix of a particular self object environment that, via a specific process of psychological structure formation called transmuting internalization, the nuclear self of the child will crystallize (p. 416).

Kohut described three conditions which must exist in order for this process to occur:

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[7]This part of the theory is frequently questioned by its proponents as well as its opponents; for the author also, it is difficult to understand how the lines can function entirely independently (except theoretically where it is possible to make artificial distinctions).

1. An earlier developmental stage during which there was adequate response to the child's mirroring and idealizing needs;

2. The occurrence of minor, non-traumatic empathic failures on the part of those responding to the child; and

3. The gradual replacement of the functions of these respondents (called self-objects) by a self and its functions.

The theoretical underpinnings for the two lines of narcissistic development rest on Kohut's conceptual framework of the bipolar nature of the self. There are two basic narcissistic functions: assertiveness, archaically represented along the grandiose line of development, and admiration, archaically represented along the idealized parent imago line. Under favorable circumstances, these develop out of the child's experiences along each line of development.

The two lines of development result in a tension arc between healthy and appropriate ambitions on the one hand, and ideals and the appropriate assessment of one's capacities on the other. In the developing child, these two poles are expressed as the need to admire and the need to be admired. In other words, the need to attach oneself to a significant and powerful other in order to derive strength and power, and the need to be admired,

mirrored by a powerful and significant other in order to feel joy and a sense of accomplishment in one's deeds. Empathic mirroring also provides a means of validating reality, a means by which the child can distinguish reality from fantasy. This ability is the basis of the capacity to moderate one's grandiosity and convert it into healthy and appropriate ambitions.

The key to the accomplishment of these developmental tasks lies in the parent's ability to be suitably empathic with the child and his or her strivings, accomplishments and failures. Faulty development occurs as a result of the parent's consistent inability to empathize with the child's needs. No single trauma, nor even series of traumas will necessarily produce pathology. Rather, the crucial factors are the parent's personalities, their more or less consistent ways of understanding the child's needs. This is yet another example of how Kohut's theory varies from Freud's. In Kohut's words,

> Such traumatic events may be no more than clues that point to the truly pathogenic factors, the unwholesome atmosphere to which the child was exposed during the years when his self was established . . . . these events leave fewer serious disturbances in their wake than the chronic ambience created by the deep-rooted attitudes of the self objects, since even the still vulnerable self, in the process of formation, can cope with serious traumata if it is embedded in a healthy matrix for the growing child (1971, p. 417).

Kohut's theory is best described by several terms which he developed, each with specific meanings. Four key terms are defined briefly here. Together with Kohut's concept of introspective-empathic observation, they form the core precepts of his theory.

Self

Kohut conceives of the self as a constellation which is at the core of the personality, as "an independent centre of initiative, an independent recipient of impressions" (1978, p. 414). Self means the integration of all those experiences that we put together as being a part of "me." The concept includes the ego although it is not limited to it. Kohut describes the self operationally, i.e., in terms of its functions.

> A strong self allows us to tolerate even wide swings of self-esteem in response to victory or defeat, success or failure. And various emotions - triumph, joy; despair, rage - accompany these changes in the state of the self. If our self is firmly established, we shall neither be afraid of the dejection that may follow a failure nor of the expansive fantasies that may follow a success - reactions that would endanger those with a more precariously established self (1978, pp. 414-415).

Self-Object

A self-object is an object (or person) perceived as an extension of the self. The self-object fulfills those functions which the individual (child) cannot

fulfill alone. The use of a self-object is phase-appropriate for a child though adults may use self-objects to enhance certain aspects of themselves. However, if an adult needs a self-object in order to experience him or herself as whole, then pathology is present. There are two self-object functions: mirroring which approves and confirms the child's healthy exhibitionism, and idealization which allows the child to first see the parents as powerful and ideal and then, by attaching to them, possess these strengths for her or himself. In therapy, the therapist is perceived as a self-object.

Self-Object Tie

Self-object tie describes the bond or attachment that develops when the patient uses the therapist as a self-object. When the tie is intact the patient experiences a state of narcissistic equilibrium; when broken, a lack of narcissistic equilibrium. The reparation of the break in the self-object tie is an essential therapeutic tool.

Transmuting Internalization

This process is involved in the gradual internalization of the function of the self-objects. Important to note, it is the function of the self-object which is internalized, not the object itself. This is a major

difference between Kohut's and object relations theories. The process results in the formation of internal psychological structure.

Line of the Grandiose Self

The developmental task assigned to this line is that of enabling the child to modify his or her early grandiosity into a cohesive sense of self, to develop pride and self-confidence independently of another admiring person, and to develop healthy ambitions. In the developmental process which accomplishes this, the child first merges with the mother, and by this merging feels omnipotent. Next, the child begins to draw strength and a feeling of value by experiencing the mother as a twin, an alter-ego. A statement describing this stage is "I am like you and you are wonderful therefore I am too." Finally, with increasing separation from mother, the child experiences mother mirroring back his or her own feelings and is able thereby to gain validation--a validated sense of what is real and acceptable and what is not. The process enables the child to gain confidence in his or her own judgment.

These three phases correspond to the child's increasing sense of separateness from mother. They comprise the three phases of development along the line of the

grandiose self: the merger phase, the twinship or alter-ego phase, and the mirroring phase. Healthy development along this line results in self-confidence, self-esteem and the development of healthy ambitions. The pathology that results from inadequate parenting along this line usually manifests itself in individuals who demand endless reassurance from others, and who behave as though other people exist only to satisfy their needs.

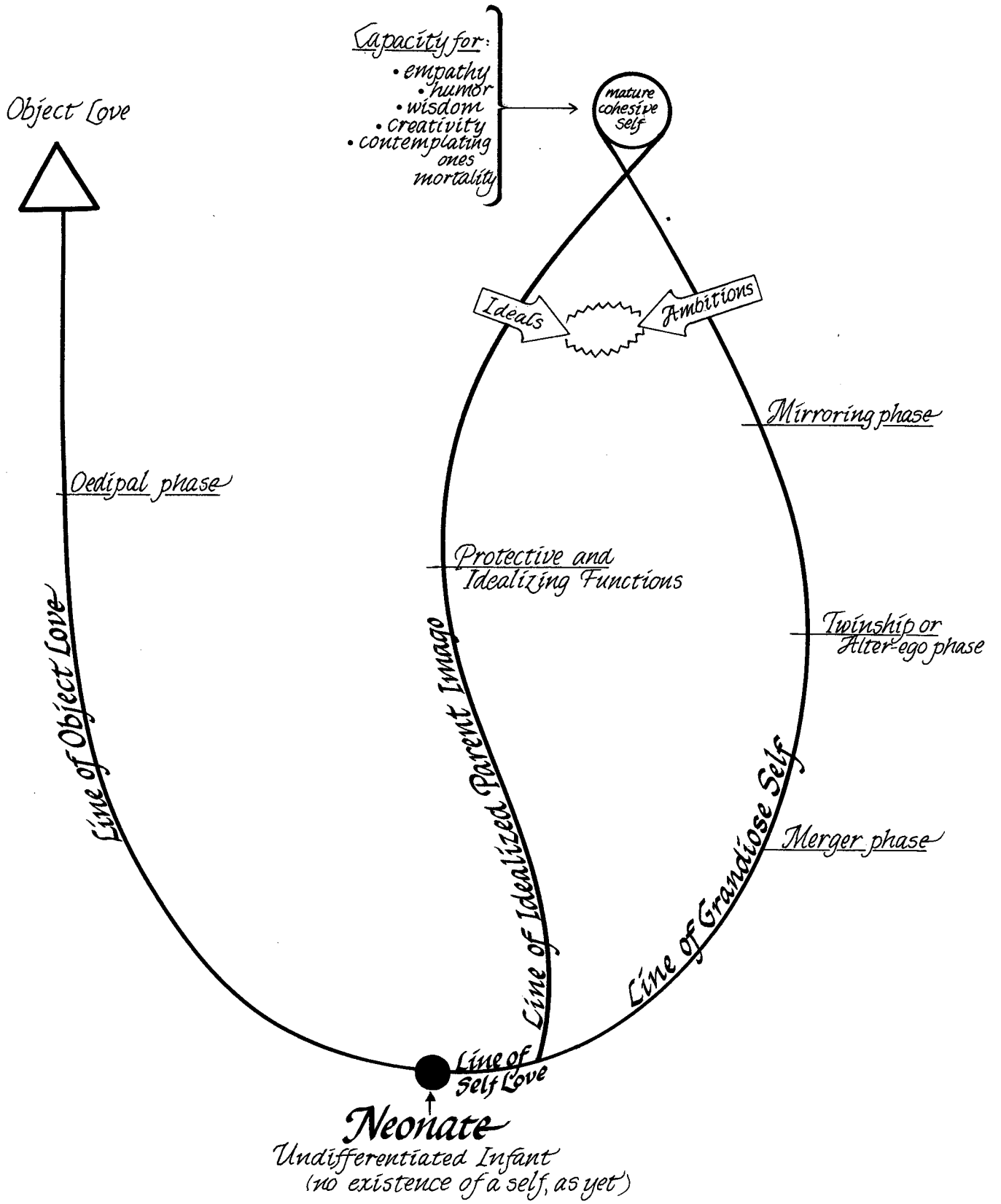
Line of the Idealized Parent Imago (or the Omnipotent Object)

This line is separate from and parallel to that of the development of the grandiose self; development proceeds concurrently. There are two major parental functions attributed to this line: the protective function and the idealizing function. The former concerns the internalization of the ability to soothe or modulate oneself at times of stress and anxiety. This happens, for example, when a mother soothes the child who has fallen and scraped a knee. The child experiences the mother's calmness and security and uses them for reassurance and safety. As in the grandiose self, the child has temporarily merged with mother's assurance and uses it to regain a sense of wholeness. Repeated episodes allow the child to gain the experience of internalizing the mother's calmness and eventually to furnish it to her or himself.

The idealizing function concerns the child's need to idealize the parent, to attribute to him or her power and perfection so that the child can feel a participant in the adult's power. The child in effect borrows from the parent those attributes with which he or she has endowed the parent and in so doing establishes a sense of wholeness. Gradually, with maturation and with the experience given by the normal disappointments of life, the child begins to de-idealize the adult, and to recognize that he can now experience within himself those functions once sought from that idealized figure. The functions of the adult are internalized. The loss of the idealization of the self object is transmuted into the child's ability to perform these functions for him or herself. The task of this line of development, therefore, is the development of the capacity to modulate one's stimulation--to regulate one's tension--and to develop an ego ideal.

When development proceeds well, the narcissistic lines of development are transformed into self-confidence, self-esteem, and the capacity to balance one's ideals and ambitions in order to accomplish life's tasks and goals. The following page more completely diagrams Kohut's concept of the developmental scheme than the earlier illustration by depicting these added components.

Development of the Mature Cohesive Self 2.



The Etiology of Self Pathology

> It is only in the light of our appreciation of the crucial influence exerted on the development of the self by the personality of the self objects of childhood, that we are able to trace the genetic roots of the disorders of the self (Kohut, 1978, p. 417).

Disorders or pathologies of the self are, by and large, the result of long-term, persistent derailments in the normal development of the self. Consequently, empathic failures along one line will produce deficits in that aspect of the self, with the attendant pathologies. Developmental incompletions occur when the parents are experienced as cold and unempathic, rejecting or destructive. Since the transformation of the grandiose self into the mature cohesive self occurs as a result of parental empathic acceptance, lack of this experience can result in a person who lacks an inner sense of self-confidence and self-assurance. This person will try to fill the gap by seeking admiration and reassurance from other people, who are then experienced as self-objects. Similarly, deficiencies along the line of the idealized parent imago can be manifest in individuals unable to accomplish anything, or finish tasks. They do not trust their own ideals, and often will not have ideals to trust. In general, self-pathology is manifest as the need to attach to self-objects in order to maintain narcissistic

equilibrium. Narcissistically vulnerable people tend to be overly sensitive to slights, in need of constant admiration. If these narcissistic needs are not adequately responded to, a narcissistic injury is experienced.

These individuals suffer deficits of the self. The treatment goal, therefore, is to help them to fill in the deficits. This is accomplished, according to Kohut, through the use of the therapist as a self-object. In effect, the patient uses the therapist and the therapeutic experiences for re-parenting. The philosophy is somewhat reminiscent of the corrective emotional experience described by Franz Alexander some 20 years earlier (1952).

The Treatment of Disorders of the Self

Since the central pathology in a narcissistic (or self) disorder is a deficient, incomplete or weakened condition of the self, the goal of therapy is the rehabilitation of this structure. Therefore, treatment does not consist of making the unconscious conscience in order to tame drives or to resolve the oedipal complex. Rather, treatment consists of healing the deficit in the self, i.e., unconscious wishes are made conscious with the goal of filling in the missing sectors of the self. The goal

of treatment is the completion of the self. The instrument by which this occurs is the self-object transference.

Individuals suffering self-pathology are people who need self-objects in order to maintain their narcissistic equilibrium. They are people who lacked adequate parenting along either or both lines of development. As adults, they attach themselves to others to fill those gaps. In Kohut's language, they establish a self-object tie to another person. Since they are fragile, they need self-objects to feel complete; when the self-objects fail them, they lose their sense of narcissistic equilibrium and are wounded. They may feel fragmented; they may withdraw, develop a myriad of physical symptoms, experience rage, become homicidal or suicidal. The pathological syndrome is designated Narcissistic Personality Disorder. Our therapeutic task is to allow ourselves to be used as self-objects in order to help each of our patients fill in the missing wedge of the whole pie. The patient's use of the therapist as a self-object establishes the self-object transference. This transference will spontaneously develop unless the therapist interferes with the natural process, since the patient's thrust is towards homeostasis--the achievement of completion of the self. By functioning as a self-object, the therapist furnishes those functions the patient cannot perform alone. Ruptures of the patient-therapist tie will occur and will correspond to the

disappointing clashes with reality that the infant experiences. The therapist will be experienced as cold or unempathic, insensitive or unfeeling. The event precipitating the break may be as simple as a phone call during the session or being taken into session three minutes late. The immediate therapeutic task then is to repair the rupture, and later to establish its genetic roots so that the process called transmuting internalization can occur.

According to Kohut, the basic treatment elements rest on a few key precepts:

1. The development of a self-object transference,

2. The use of empathic observation as a therapeutic tool, and

3. The process of transmuting internalization.

This work focuses only on the first precept--the development of a self-object transference--since the function of this review is to explain the theoretical background for the next chapter. The reader who may wish a fuller explanation is referred to the bibliography section entitled "Self-Psychology."

The Self-Object Transference

The transference relationship in self-psychology theory as in other analytic theories is at the center of the treatment process. However, in self-psychology it is also at the center of the diagnostic process, for the narcissistic transferences which develop are pathognomonic, and can be used to diagnose the specific narcissistic deficit the patient suffers. The transference relationship is the key to the recognition of first, the existence of a narcissistic deficit; second, the quality of that deficit; and third, the developmental genesis of the deficit. These transferences are subdivided into two types, which correspond to the two lines of development:

1. The mirror transference in which the patient's need for accepting and confirming mirroring is reactivated, and

2. The idealizing transference, in which the patient's need for merger with an idealized source of strength and calmness is reactivated.

Thus, the nature of the transference formed is the clue to the patient's pathology, not the presenting symptoms.[8]

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[8]As indicated above, these patients present a myriad of symptoms. Just as a cough and sore throat can indicate anything from a mild allergy to a serious infection, so the symptoms of a Narcissistic Personality

Further, the quality of the transference relationship established is usually so intense that the intensity itself can be a clue to the nature of the disturbance. For example:

> Mrs. W., a woman in her mid-thirties, spent much of her fourth session questioning me about the furnishings in my office, asking me whether I had chosen them, telling me she found them disappointing, that I looked as though I had nice taste but they looked--well, shabby. Her comments sounded puzzling initially, since in our first session she had commented, almost fervently, on the comfortable ambience of the room. Her displeasure became more and more intense. She seemed to be using the furnishings to devalue me.
>
> Through a lengthy process of acknowledging her displeasure and wondering whether I had offended her, I learned that during our previous session, I had not commented on a rather important and striking new feature of her grooming. My inattention felt to her as though I were criticizing her. She needed my mirroring to affirm and confirm her

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Disorder are common to many pathologies; mild to extreme anxiety, depression, suicidal ideation, lack of self-esteem, shame, anger and rage.

feelings about herself and her appearance. Without it, she experienced fragmentation, became angry and sought to devalue me. As an additional note, the intensity with which she commented on the furnishings in the first session was unusual. It provided a clue to this woman's need for a self-object.

Another example is provided in the following vignette, furnished by a colleague.

I had telephoned Julie to give her some information about a rehab appointment. It was the end of the day and I was a bit rushed because I had another appointment immediately following. During the conversation, Julie hung up on me. I was surprised because I couldn't think of anything I had said that would evoke that behavior. I tried to call her back but she refused to take the call. It was difficult to reestablish contact, but when I finally did, I learned she believed that she heard me say, "I am too busy and I don't have time for you." She did hear my rushed affect but for her it was as if indeed I had said those words. That produced a break in the tie. When I finally saw Julie, and she told me of her feelings, I empathically told her that it must have been very upsetting for her to think that I would say I was too busy for her.

> Further, I expressed how important it is to her that she feel that I care about her and her well being. I acknowledged that I knew she had had numerous rejections in her life and when she felt I was too busy to talk to her, she not only felt rejected but also experienced her early feelings of being unimportant. In so doing, I acknowledged the break in the tie, clarified what triggered the break, empathically observed her feelings and made a genetic connection. Julie could then experience a reestablishment of the tie and we were able to move on.

In each of these instances, the rupture in the tie was repaired when the therapist was empathic with the patient's need for the self-object. There was no issue of gratification involved, nor were interpretations offered. Rather, the patient's wish for attachment to the self-object was acknowledged.

To summarize, the narcissistic transference develops remarkably quickly with unusual intensity. Often, the therapist has the sensation of not existing as a separate self, but only as an extension of the patient. The quality of the transference can help identify which sector of the self is deficient. The patient suffering a deficit in the grandiose line will likely have had

numerous fleeting relationships with people who functioned as self-objects for a time, and provided some degree of admiration or mirroring.

In the transference, these people will attempt to display themselves and to evoke the therapist's admiration in an attempt to counteract their inner sense of worthlessness. The therapist is called upon to provide the lacking mirroring experience.

CHAPTER 6

AN INTEGRATED, CLINICAL APPLICATION OF HEINRICH RACKER'S THEORY OF COUNTERTRANSFERENCE AND HEINZ KOHUT'S SELF PSYCHOLOGY THEORY

> . . . One can describe a continuum of countertransference reactions ranging from those related to the symptomatic neuroses at one extreme to psychotic reactions at the other, a continuum in which the different reality and transference components of both patient and therapist vary in a significant way. When dealing with borderline or severely regressed patients, as contrasted to those presenting symptomatic neuroses and many character disorders, the therapist tends to experience, rather soon in the treatment, intensive emotional reactions having more to do with the patient's premature, intense and chaotic transference and with the therapist's capacity to withstand psychological stress and anxiety, than with any specific problem of the therapist's past. Thus, countertransference becomes an important diagnostic tool, giving information on the degree of regression in the patient, his predominant position vis-à-vis the therapist, and the changes occurring in this position.
>
> Kernberg, 1976, pp. 179-180

The task undertaken in this chapter is the investigation of utilizing countertransference reactions as a diagnostic tool. The means of this investigation is the application to clinical data of Heinrich Racker's model for understanding countertransference responses. The information gleaned from this application is then used to determine whether it is possible to obtain diagnostic information about the patient. Several basic questions are addressed, and clinical examples are used to suggest answers to these questions:

1. Can countertransference reactions be used to identify the presence of a narcissistic personality disorder as defined in self psychology?

2. Can countertransference reactions be used to help identify:

   a. The self-object transference as defined in self psychology, and

   b. The nature of the narcissistic deficit of an individual designated as a narcissistic personality disorder?

In The Analysis of the Self (1971), Kohut implied the possibility and validity of using the therapist's countertransference diagnostically. He examined the narcissistic transferences along each line of development

and discussed them in terms of their effects upon the analyst. He found that distinct varieties of transferences developed and that each corresponded to the developmental deficit suffered by the patient. Each of these transferences produced correspondingly unique countertransference feelings in the therapist. Although Kohut did not explore these coincident relationships thoroughly, the implication seemed clear, i.e., that someone could do the work of examining a transference manifestation with its corresponding countertransference manifestation, then utilize that correlation as a method of using the countertransference to diagnose, elucidate, clarify the transference--a back to front, perhaps, way of diagnosing. The value seems clear. After all, one cannot use presenting symptoms diagnostically, for the narcissistic patient population presents a myriad of symptoms. One of the basic precepts in analytic psychotherapy is the use of the transference for diagnoses. This study attempts to augment that precept with the use of countertransference as well for diagnosis.

Kohut said that the narcissistic transferences along both lines activate corresponding archaic deficits in the therapist. That exacerbation can be used to diagnose the patient. For example, if a therapist feels empty or drained, feels as though he or she exists only as a mirror for the patient's grandiosity rather than as a

separate person, perhaps the therapist is in the presence of a mirror-hungry patient, one whose deficit lies along the line of the grandiose self and who therefore searches incessantly for mirroring self-objects. The therapist's feeling of emptiness, non-existence, being drained can parallel the patient's, and thereby indicate a mirroring self-object transference. They can also form the counterpart to the patient's feelings. The patient's use of the therapist as a self-object can leave the therapist feeling non-existent and drained.

The archaic quality of the patient's need and its intensity can impose emotional hardships upon the analyst. Being treated as if one were only an extension of the patient's mind and body deprives the therapist of even minimal gratification. As a result, it is difficult to tolerate a situation in which one is reduced to being a mirror for a patient's infantile narcissism. Yet, the feelings aroused can be diagnostic of the patient's pathology. The traditional thinking about countertransference used such responses to give information about the therapist.

By contrast, Kohut's and Racker's theories indicate that these countertransference responses can give information about the patient. This study's contribution is to combine and extend their theories, and demonstrate

the application of the results through the illustrative case material. There rises, however, a technical point of divergence between Racker and Kohut. Kohut maintains that the primitive quality of the patient's pathology excites a corresponding primitive aspect of the therapist, i.e., a process of identification occurs that reactivates the therapist's unresolved narcissistic deficits. If the therapist can consciously recognize and control this primitive aspect, then the countertransference feelings can be used diagnostically. Racker viewed the phenomenon slightly differently. For Racker, the therapist's archaic narcissism is not necessarily aroused. The countertransference Kohut refers to would have been conceptualized by Racker as a transferred component of countertransference, a component which gives information about the therapist, not about the patient. Racker seems to feel more comfortable than Kohut in rejecting Freud's concept of the countertransference as only a symptom of pathology. It is reasonable that Kohut's reluctance to argue openly with Freud's formulation resulted in his dealing with the issue incompletely. In any event, Kohut seems to understand countertransference primarily as an expression of pathology in the therapist while Racker does not. Kohut hints at the possibility of something else giving rise to the therapist's feelings. He says that when this occurs it is not

countertransference, but does not name the phenomenon. He offers a method to recognize the difference: if the difficulty the therapist experiences goes away with consultation or self-examination, then it is not true countertransference. If it does not yield it is, and the therapist must accordingly, i.e., undergo further analysis.

For Racker, these aroused feelings derived from an identification or an empathic merger with the patient; that is, from the therapist's ability to merge with the patient while still retaining his or her cognitive boundaries. Thus, the information obtained will be information about the patient since the therapist is feeling what the patient has projected into the therapist. The therapist is either concordant with the patient or is the complement to the patient's feelings. While Kohut says that the countertransference responses come from the therapist whose deficits become exposed as a result of the patient's onslaught, Racker says that the patient's deficits are expressed through the therapist's countertransference. Kohut deals with the neurotic countertransference, as does Racker. While Kohut tries, conceptually, to fit all countertransference responses into the classical framework, clinically his use of countertransference is not so limited.

The technical question of whether the therapist's unconscious experience is an identification or the arousal of unresolved primitive material or both cannot be answered in this work. The issue is another topic for study. Some comments, however, can be addressed. The question basically is: how can one know when countertransference reactions can be utilized and when not? How can one know whence they originate? In this author's opinion, countertransference reactions originate in the therapist, in the patient and in the interaction between them. It is the therapist's ethical and professional responsibility to acquire a level of self-awareness that allows him or her to become conscious of his or her intrapsychic workings and to identify personal conflicts as such. (The most effective means, in this author's opinion, is personal psychotherapy.) Countertransference reactions can always be utilized. They give information about the therapeutic interaction, about what occurs between therapist and patient, as well as about the internal objects of the patient and of the therapist. The distinction between neurotic and non-neurotic countertransference becomes less crucial when the therapist sustains his or her responses and investigates them for information about the patient. Kernberg (1976) and Searles (1979) believe that even neurotic countertransference gives diagnostic information

about the patient, since it is the relationship between therapist and patient that excites that particular material in the therapist.

To reiterate, the therapist must be able to go beyond the initial recognition of the aroused feelings to sustain them, identify them and finally use them to give information about the patient. A process of cognitive and emotional investigation is involved; one formulates a hypothesis, tests it clinically with the patient and evaluates it. This process is demonstrated in the case material of this chapter.

For the purposes of this study, only the identification aspects of the countertransference are considered, not the transferred component. The therapist's empathic identification picks up and internalizes that which the patient sends. These feelings can be used diagnostically, to illuminate and elucidate the narcissistic transference.

Racker's definition of countertransference included the whole of the therapist's images, feelings and impulses toward the patient. Although he did not so identify them, Kohut's discussion utilized the therapist's feelings about the therapist as indicators; i.e., the therapist feels empty, non-existent, etc. This study combines the two. The therapist's feelings about the therapist as well as about the patient are seen to give information about the patient.

Therefore, the definition of countertransference used in this study is broad: all of the therapist's responses to the patient. To explicate that terse definition, countertransference is defined as all of the therapist's responses--conscious and unconscious, feelings and associations, thoughts and fantasies--to the patient, to the patient's material and affects and to the interaction between them. These responses encompass the therapist's self-feelings as well as those about the patient.

The effect of primitive disorders on the therapist is related to the ego boundary difficulties of the individuals exhibiting these disorders. Since their boundaries are not clearly defined, they project their material onto the therapist. In the process of being empathic, the therapist is open to an empathic merger. One can draw a parallel between the therapist's susceptibility to projection and the communication of moods between a baby and its mother. A baby's emotional state will reflect the mother's mood and the mother's moods are reflective of her baby's.

In short, the therapist's self-feelings can be utilized as part of the identificatory process between therapist and patient, inasmuch as the therapist's empathic resonance with the patient results in a heightened receptivity to the internalization of the patient's projections.

In this light, Kohut's idea that the therapist's stirred up narcissistic feelings derive from the patient's narcissistic deficits are right. The therapist's self feelings can be used to identify the patient's narcissistic deficits.

In this chapter, it has been shown how narcissistically disordered individuals are inordinately trying to the clinician, how the demands are many and intense, the gratifications few and diffuse. The literature is replete with case accounts of stuck and unproductive analyses. Very little of it describes the authors' countertransference reactions. Rather, the literature talks about the patient, rarely focusing on the therapist except by implication. Reading between the lines makes it possible to imagine how difficult the patients seemed and how ego devastating their resistances felt to their therapists. Kohut, in "The Two Analyses of Mr. Z" (1979), describes the phenomenon of two analyses of one man. The first analysis was conducted along traditional lines, with fairly classical interpretations of transference manifestations. The second analysis was a product of Kohut's changed understanding of the man's core pathology. However, even here is little direct information about the impact of his pathology on Dr. Kohut.

Thus, case material rarely reveals anything of the writer's experiences in the therapeutic interchange.

Robert Langs (1980) remarked on this phenomenon in a published dialogue with Harold Searles:

> . . . that most of the presentations relate material about the patient, while virtually never mentioning anything about the analyst (pp. 96-97).

A few authors have described their countertransference responses, e.g., Margaret Little (1951), Paula Heimann (1950), Harold Searles (1979), Otto Kernberg (1976), and Gerald Adler (1972). But even these authors, despite their candid descriptions, mostly did not record how they used their reactions or how the patient responded. Searles did, however his patient population was primarily schizophrenic or severely regressed. Thus, there is little countertransference case material in the literature and consequently, the case material in this chapter is drawn largely from the author's material. The material for one case example was contributed by a colleague who was candid in revealing her countertransference responses, her reactions to them, and her subsequent interventions.

The Therapist's Reactions to an Idealizing Transference

The idealizing transference is, as will be recalled, a reactivation of the patient's need to idealize, to attach to an omnipotent and omniscient other so as to derive strength, power and the ability to regulate one's tensions.

The patient perceives the therapist as a self-object; that is, as an object whose functions complete the patient. Without the self-object, the patient's narcissism is not in equilibrium. The patient expects to be able to exert the same control over the self-object that he or she would expect to have over his or her mind and body. As one might anticipate, the intensity of this unconscious demand and attachment creates an intense response in the therapist.

One of the manifestations of this transference is that the patient will tend to idealize the therapist and do so remarkably quickly and strongly. The therapist will experience both pleasure and discomfort with the idealization. The experience of pleasure comes from being confirmed and acknowledged as a good therapist. The experience of displeasure comes from the fear of the disillusionment that will likely follow. As pleasurable as is the grandiose feeling, it is tempered by the fear of the responsibility that accompanies it. Can this experience now be turned around to enlighten the therapist about the patient? If these feelings experienced by the therapist are identifications, then they should give information about the patient or the patient's early objects. Indeed, they can do both. The therapist responds to the patient's raw, unmodified and unconscious need to admire, to adulate, to link up with or attach to a perfect and admirable other

in order to feel a sense of inner cohesion. The therapist can understand, from this feeling of being so admirable and ideal that he or she is responding to a narcissistic deficit; specifically to a deficit in the idealizing aspects of development. The therapist is experiencing complementary countertransference. The patient is looking for an ideal object, the therapist is feeling as the ideal object.

The following case vignette is an illustration.

Case Example 1: Elizabeth

> Elizabeth, a 24 year old, delicately featured, extremely thin young woman came into her first session. She was agitated, confused, depressed and fearful. She was concerned about her relationship with the young man she lived with, concerned that it was not going well and they had just decided to marry in a few months. As she spoke, I asked a few clarifying questions, but primarily listened, occasionally reflecting her words. Towards the end of the session, she smiled broadly and said she felt good. She had never had the feeling that anyone listened to her before, or understood her the way that I had. She said she knew that I understood her, and that she would be

able to talk to me. She thought I was a very good therapist.

My initial response was pleasure--almost elation. I agreed with her. I like feeling myself a good therapist and felt I would be so for her.

I experienced complementary countertransference. I thought about the deficits that would be likely to have occurred in her life, and compared my thoughts to the information she had given me. I hypothesized that she might have had disappointments with other idealized objects in her life. I was empathic with her need for a strong, idealizable figure to whom she could attach. I felt her attachment to me.

Thus, at first I experienced the power Elizabeth had projected into me as my own, and I felt elated. Since this is not my usual mode, this uncritical self-elation, I recognized this feeling as a countertransference experience. It was a complementary identification. We both felt elation with my professional skills.

I next felt what it must be like to be her, to experience myself as empty and then to experience the relief at feeling connected to someone who could fill that emptiness. I thought about a small child who falls and skins a knee but will not cry until she runs home to

mother. Once in mother's presence, she feels safe and contained and so, can let go and cry. I felt as though I were that mother for her.

But then, very different feelings followed: a complex of emptiness, fatigue and dread. I wondered whether my feelings were concordant with Elizabeth's, and whether they signified that she feared the loss of me as an idealized object. Those musings led me to speculate about her early objects and about the deficits in her self. I hypothesized that her childhood experiences failed to teach her to internalize a sense of her own power and strength, and thus she was required to gather them via an attachment to someone perceived as powerful and strong. I guessed that she experienced disappointment with her parents; that they were not able to be powerful self-objects for her. In brief, my countertransference feelings led me to think she was beginning to form an idealizing transference with me.

Subsequent interviews confirmed my diagnosis and guesses about her parents. Her father, perceived by Elizabeth as a critical and punitive man, was unable to respond to his daughter with appreciation or warmth. An alcoholic, he would withdraw, after criticizing her, into episodes of depression. Her mother was an inconsistent and vain woman, concerned with impressions and appearances.

Neither was available to Elizabeth.

Elizabeth's attachment onto her fiance intensified as the marriage plans proceeded. She placed greater and greater demands upon him to fulfill self-object functions for her. So long as they remained single, the disappointments she experienced in their relationship were tolerable. She felt as though she could always find another self-object. Marriage, however, would seal off the escape hatch for her and Elizabeth became frightened. As her self-object transference to me intensified, her need to use her fiance as a self-object diminished, as did her demands upon him.

In this example, my countertransference responses described my feelings about myself as well as about Elizabeth.

The case of Elizabeth exemplifies an idealizing transference developed as a result of a deficit of the self, in the idealizing sector. That sector represents one parental function attributed to the line of the idealized parent imago. There is a second function attributed to the line of the idealized parent imago: the tension-regulating function. As may be recalled, the internalization of this function allows the individual to moderate anxiety, stimulation or excitement and to utilize previous experiences in order to reduce stress. In short, the

internalization of this parental function furnishes an individual with the capacity for self-soothing. The lack of this capacity reveals itself in a patient who presents with intense reactions to seemingly simple events. This patient looks to the therapist to fulfill those soothing functions which he or she is not able to perform.

This patient forms an idealizing self-object transference that expresses slightly different needs than did Elizabeth's transference. The therapist's perception is often one of a person who feels hysterical, overstimulated, pouring forth affect and content seemingly inappropriate for that situation. Often, the therapist will feel anxiety, feeling that he or she should do something to calm the patient but does not know how. Assuming that there is nothing in the content of the material that is anxiety-producing, the therapist can assume the presence of derived or induced countertransference responses and begin a diagnostic or identifying exploration. The following hypothetical development by the therapist serves to illustrate such an exploration.

The content of this material is not anxiety-producing for me. I can see that this individual is having difficulty calming and soothing himself, moderating his own anxiety. He feels to me as though he were an overtired child who can't stop screaming. I feel as

though I need to calm this man down. This is an unusual feeling for me to have. I don't usually assume that kind of responsibility for the people I work with. Perhaps I am reacting to his unspoken and unconscious need for me to fulfill that function for him, to be a self-object for him. If so, then I am experiencing complementary countertransference. I am also experiencing concordant feelings in that I too become anxious. My concordant feelings tell me about this patient's self-experience; he is anxious and cannot quiet the anxiety. My complementary feelings tell me that he needs someone to perform a soothing function for him. I can conclude that this person experienced inadequate parenting along the idealized parent imago line of development, and particularly along the tension regulating aspect of that line. I can then make some comment which addresses that need in him. I can help him to recognize his difficulty in self-soothing and his need to have someone fulfill that function.

The above process is illustrated in the following case example of a woman whose deficit reflects inadequate parental care during her childhood.

Case Example 2: Eloise

Eloise is middle-aged. She was referred by a colleague who felt I had particular expertise which would be useful in her case. Eloise began the

session saying that while she had asked for help with a specific problem, she was concerned about a totally different issue at the moment, one that had traumatized her and that left her badly frightened. Her speech was rapid, her voice high-pitched. As she spoke, her many hand gestures were constricted and rapid, jerky and sudden. She started telling me of the recent traumatic event in her life, jumped to an old event, jumped back to the original one and again introduced a new subject.

I felt anxious and found myself worrying. My worry intensified and I told myself that I did not know anything about this woman. I did not know how she coped in previous crises. I worried about whether she could contain herself, whether she would fragment. I began to think about referring her to a physician for medication. I heard myself saying to myself "I can't contain her, I cannot do it for her. I need help. I need to find someone to help me." My plea for someone to help became my clue. I was looking outside myself for help, for some magic person. Perhaps I was reflecting her feelings? I was experiencing countertransference.

My countertransference responses were concordant in that my feelings paralleled hers. She felt anxious, I felt anxious; she felt incapable of coping, so did I.

My anxiety and concern paralleled hers. My need to take responsibility for her was complementary. It was the counterpart of her need for someone to take care of her. I don't normally assume responsibility for my clients' anxiety, so I knew that I was experiencing her wish for someone to take care of her, to calm her down. My feeling of "I need help" was a concordant identification. I could experience what it felt like to be her, to feel incapable of taking care of herself, wishing for someone to care for her. My concordant countertransference told me of her need, of the deficit in her self. It reminded me of her self-experience. I was able to experience her feeling of fright, of helplessness, of lack of perspective. She seemed to be in a great hurry to get her story out. It became clear that some perspective must be brought in, that she needed to experience soothing. So, I said to her, "It's all right, you can take your time. I'll listen to everything you have to say, we still have plenty of time." Slowly, she began to calm. Then, somewhat more comfortably with less pressure, she began talking in a more coherent manner and began telling me of what frightened her. She was able to calm down, to moderate her anxiety because she could hear me, experience me as a soothing assuring self-object. I could be that for her, because I could sustain my discomfort long enough to recognize it as a countertransference

reaction and then think about its etiology. Subsequent interviews substantiated my impressions. Eloise is the daughter of a psychotic mother, and an absent, non-involved father. Her mother's behavior was unpredictable, and intense. She was thrust into a parental role early in her development. My countertransference reactions offered the first diagnostic clue to her pathology.

This section has focused on the idealizing transference. The next section focuses on the mirroring transference.

The Therapist's Reactions to a Mirroring Transference

Since the therapeutic mobilization of the grandiose self results in different clinical manifestations than does the idealizing transference, the therapist is exposed to somewhat different emotional risks. Whereas in the idealizing transference, the patient sought someone perfect and strong to idealize, in the mirroring transference the patient seeks admiration from someone strong and perfect. Whereas, in the idealizing transference, the therapist was called upon to be strong and powerful and admirable, in the mirroring transference the therapist is called upon to be strong and powerful and admiring of the patient's strength, power and performance.

The therapist is assigned the function of a self-object and consequently is not acknowledged as a separate individual. The therapist is required to perform self-object functions for the patient with little or no recognition. The therapist's narcissistic supplies are not maintained. To the contrary, the therapist often feels depleted at the end of a session. Imagine what it must feel like to offer a therapeutic gem to a patient only to have it rejected out of hand by one whose sole interest is the acquisition of self-affirmation and self-confirmation. The verbal and non-verbal behavior of patients who suffer deficits of the self cannot engage the therapist's unconscious responsiveness in the same way as can the associative material of the transference neuroses, for the latter are object-directed. The narcissist is self-object directed. This self-preoccupation is the central difficulty-creating factor in a mirroring transference. A patient with deficits in the grandiose aspect of the self is only interested in self-confirmation. The other--the therapist--does not exist as a separate being.

The effects of the deprivation of human emotional contact on the therapist can be seen in such symptoms as sleepiness, boredom, restlessness or inattentive behavior. Often the therapist will react by withdrawing via anger, boredom or disinterest. In the idealizing transference

the therapist feels connected with the patient, since that patient places so much importance onto the therapist. In the mirroring transference, the therapist experiences being negated. The patient's focus is on him or herself and the therapist exists only to mirror, affirm or confirm that focus. One's countertransference reactions often are characteristic of a mirror transference.

The first illustration is a case that only tangentially describes a mirror-hungry personality, yet imparts the flavor of the countertransference described above.

Case Example 3: David

> David, 26 years old, was ill with Hodgkins disease. He had been referred by a relative who was concerned with his increasing anger and depression. From our first session, David was angry in a quiet and withholding fashion. He discussed his disease intellectually, disgorging information acquired by intensive study. He was thorough familiar with his disease, the research pertinent to it and his own course of treatment. He spoke of his disease dispassionately, as of an event external to him.

My initial response to David was a surge of compassion and maternal feelings. My feeling puzzled me, since David had not connected with me in any observable

way. He did not look at me, only at the window behind my head. His voice was nasal and pointed, reminding me of a lecturer. He gave me almost no opportunity to speak. He responded to my few comments with a throaty acknowledgment that was only a sound, and then went on with what he was saying. My initial response of compassion was a complementary identification, for as I came to know David, I came to understand the life-long fear and loneliness his behavior hid.

After a few sessions, I found myself feeling impatient, bored and increasingly angry. He told me what he wanted me to say to him, how he wanted me to respond and what he wanted us to talk about. I experienced David as angry and so viewed my anger as concordant countertransference. David did not evidence any feelings of disconnection or disinterest. To the contrary, he seemed invested in what he told me. Thus, I viewed my impatient boredom as complementary. From the complementary stance I hypothesized that David did not want to form any attachment to me, that he wanted to continue using me only as a reflector. My concordant feelings told me of the anger and fear within David. I decided to remain receptive. Subsequently I learned that David had experienced his parents as impatient and disinterested. He experienced their withdrawal and felt that they did not exist for him.

As it became known that his disease was terminal, David's insistence on controlling the interview (for so I had understood his behavior) decreased. Instead, David began to discuss the ending of his life. He discussed his plans to accelerate the completion of the work he was doing, his funeral wishes, his plans for his survivors. Throughout the last few months of our contact, David's sessions amounted to an accompanied soliloquy. He spoke and I listened. If I commented, he impatiently ackknowledged that I had said something and went on about his discourse. On one occasion, I observed that he seemed to prefer that I remain a background figure for him. He looked at me briefly, grunted acknowledgement of my comment and continued. My feelings were confused. I was angry, and felt as though I did not exist for him. I found myself being reduced to a background for his comments. I felt as though I need not be in the room at all, that all he needed was a tape recorder and a chair. Simultaneously, I experienced shame and guilt. This young man was dying. I had no right to be critical.

As I examined my countertransference, I recognized that I was indeed a self-object for David. His contact with me enabled him slowly to withdraw from the world, slowly to decathect himself. In truth, I did not exist for him. My not existing as a separate person allowed him

to pursue his withdrawal. My countertransference feelings moved from concordant ones to complementary ones and ran just ahead of his shifts. As my anger abated, so did his. As I became more comfortable with his non-connection with me, so he began to be more comfortable establishing new ways of connecting that allowed him still to control the depth of the connection.

David's behavior exemplifies the demands placed upon the therapist in a mirroring transference. The therapist has no separate reality, instead exists only as an extension of the patient and for the patient's purposes. My counter-transference feelings were complementary. They formed the counterpart to his feelings and enabled me to use them to anticipate David's movement in therapy. Thus, this case illustrates the countertransference responses to a mirror-ing transference.

Case Example 4: Louise

> Louise is a 30 year old woman, divorced and currently living with her child in her parental home. She was "sent" into therapy by her mother who worried that her daughter would never remarry, since she sat at home all the time and refused to go out. In truth, Louise had been wanting to talk to a therapist for some time, and was glad that her mother pushed her into starting.

From the first, it was difficult understanding what Louise was saying. She cried easily, complained incessantly about family members, neighbors, associates at work. Her speech made understanding even more difficult. Although reasonably well educated and native-born, her use of language was imprecise and vague. Often she did not complete sentences but relied on hand gestures and "well, you know" to complete her thoughts. She started sentences with "Do you remember when . . . " and would ask whether what she said made sense. It became ever harder to remain attentive and to remember her long tales of injustices. At times it seemed as though I had not heard her; I could remember her words well enough but could not connect her affect with the content. I attempted to structure what she was saying and she resisted staunchly. I was wrong. That was not at all what she felt or said or meant.

I had difficulty remembering what occurred in our sessions. Within a few minutes of her leaving, I had difficulty remembering anything about our interchanges. It was as though she had not been there. It was only after our twelfth session, as I was trying with little success to make some notes, that I first began to examine my countertransference reactions. I simply did not care. I felt unusually devoid of affect, and confused. I was however aware of my feeling that Louise's complaints reflected her failings.

This was an unusual stance for me, I don't usually judge my patients. It is also unusual for me to wait twelve sessions to explore my responses. I recognized that Louise related to me in a fashion that deprived me of contact with her. Even her words and sentences were incomplete. My feelings were more in accord with the people she complained about than they were with her.

This is a typical complementary stance. I thought of her relationship with her mother. The little I knew indicated that it was an angry relationship. Her mother complained about her own lot, then criticized and berated Louise. Louise held her mother at bay, while hungering for emotional contact. I was in the complementary position. She denied me any emotional contact with her, as she was denied by her mother, and in turn denied her mother.

I began to fantasize a complete interchange with her, replete with whole sentences. I experienced fright. Using my fear as a clue, I considered the possibility of concordant countertransference. If my fear tracked hers, what was the source of it? Could she be frightened of being understood? She is not psychotic. Perhaps my feeling was representative of her wish, and the fear of disappointment when the wish is not fulfilled. My comment was "sometimes I think that you would like to have the feeling that someone understands you." She stopped for a

few seconds, and slowly said "yes." She then resumed her disjointed complaints. After a few minutes, I again commented, saying "I think you'd like to have the feeling that someone understands how much all this hurts you, how much you suffer." This time she stopped and began to cry.

As both of us came to understand, she had had a deficient upbringing along the line of the grandiose self. Her mother, a frightened and defensive women had been unable to accept, let alone mirror, her daughter's feelings. She instead criticized her daughter, pointing up to her the way in which she brought misery on her own head. Louise's disjointed way of speaking was a defensive maneuver, to keep her feelings safe from further criticism.

In this example, the complementary countertransference, which told me of her earlier relationships with other people in her life consisted of the therapist's feelings about both the patient (she is a complainer) and the therapist (I am devoid of feelings for her). The concordant countertransference, which told me of Louise's internal experiences, consisted of the therapist's feelings about the patient (she brings her problems on herself).

This final example of mirroring transference is a case example provided by a colleague. For uniformity and ease of reading, it also treats the therapist in the first person.

Case Example 5: Sandra

Sandra is petite, red-haired, freckle-faced, and appears much younger than her 26 years. She is gamine-like, looking as if she would be fun to be around, lively and good-humored. But her appearance bears little relation to her personality. Sandra complains incessantly, is angry most of the time, critical of most with whom she comes into contact, and in a nearly constant state of disappointment. Everyone fails her in every way. They mostly do not listen to her and do not understand her when they do listen. They are inconsiderate and keep trying to push her into activities she doesn't want. This includes her two previous therapists.

Sandra spends the entire hour talking. Her tone of voice, while soft, is imperious. She rarely stops to take a breath and when she does, it has the quality of a complaining sigh. She drones on and on and on, mostly about how terribly put upon she is. She is almost invariably complaining, criticizing and filling in with excrutiating detail. To make any comment, I must raise my voice and talk over hers, interrupting her. When I do she becomes angry and accusing. I do nothing for her and she gets no help from this place.

I hate seeing her. I dread each hour. When she leaves I feel exhausted. When I examine my feelings, I am torn between sadness and relief when she does not show up. There are times when I could wring her neck. She is very difficult, I would love to get rid of her. Then I am judgmental about myself. I feel inadequate as a therapist and angry. I feel uncaring. My anger goes hand-in-hand with feeling futile. She doesn't need me there. Any department store dummy will do. I am reduced to a robot, someone whose only role is to listen and feed back what she has just said. Any attempt to do anything else begets her rage.

This is not my customary way of feeling toward a patient. It is not characteristic of me to respond with such intensity. I do not feel the way I usually do about myself when I am with this patient. The intensity of my countertransference reactions and the rapidity with which they developed suggests that I am with someone who is narcissistically deficient. I begin to use my feelings to think about the patient.

These countertransference reactions are feelings about the therapist as well as the patient. The feelings engendered about the patient are two-fold:

She is a pain in the neck, impossible, self-centered and complaining. She does not care about anyone

else. Yet, I feel sorry for her. Underneath all that complaining is suffering. She is lonely and in pain.

The therapist's self-feelings are also two-fold: I feel inadequate and uncaring at times. I feel futile, as if I were worthless. I feel superfluous at times. I don't need to be there. On the other hand, I also feel compassion for her. I feel as though I can, at times, be in tune with what her complaints express.

The concordant feelings give the therapist information about the patient's self-experiences, about what it feels like to live inside this woman. The therapist's feelings of compassion, feeling sorry for Sandra, feeling that she is lonely and in pain are concordant identifications. So are the therapist's self-feelings of being drained and exhausted. The concordant feelings reveal that Sandra experiences herself as empty, non-existent, narcissistically vulnerable, in need of others to tell her that she exists. The assumption was made that Sandra suffers a primary disorder of the self and that the deficit lies in the realm of the grandiose self.

The complementary countertransference reactions would give the therapist information about the patient's self-object experiences, especially in early life. The therapist's feelings of anger, rejection, dislike, non-existence are all complementary. So is the feeling of

inadequacy, never being able to do enough, and of not caring. These feelings are the counterpart of the patient's incessant demands. These feelings tell the therapist that Sandra's mother was, quite likely, too preoccupied or too busy for her daughter, rejecting her, unwilling or unable to listen and attend to her. These impressions tend to confirm the assumption that Sandra's primary deficit lies along the line of the grandiose self and that Sandra was denied the experience of an empathic merger with a parental self-object.

I suggest that Sandra might like to have the feeling that I understand how difficult a time she usually has, and how very lonely she sometimes feels.

At these times, Sandra's affect changes. She softens, her speech slows down a bit, and she can actually listen and hear what it is I am saying to her. Sandra remembers these comments and uses them throughout the week.

The few and small changes she made all grew out of her responsiveness at these times. However, she is inordinately quick to take offense, to feel hurt and slighted. So I find myself repeating this process over and over, each time making another small inroad that can be built upon. I recognize the importance of my self-object function to Sandra and recognize the intensity of this mirroring transference.

Summary and Conclusions

The foregoing case illustrations have demonstrated the diagnostic use of countertransference reactions, using Racker's formulation as a conceptual model. By focusing not on what the patient is saying but instead on the reaction evoked in the therapist, the therapist becomes aware of the powerful impact the patient has and reciprocally, how powerful the therapist seems to the patient. Kohut implied the possibility of using countertransference reactions diagnostically when he described the impact of the narcissistic transferences upon the therapist:

> Exposed to a mirror transference, the analyst may become incapable of comprehending the patient's narcissistic needs and of responding to them by appropriate interpretations. The most common dangers to which the analyst is exposed vis a vis the twinship and merger are boredom, lack of emotional involvement with the patient and precarious maintenance of attention including such secondary reactions as overt anger, exhortations, and forced interpretation of resistances as well as other forms of the rationalized acting out of tensions and impatience (1971, 273).

As the case examples above indicated, Kohut's theoretical guesses are rather accurate and the process can be worked backwards, so to speak, i.e., the therapist's countertransference reactions can be used first to recognize the existence of a narcissistic transference and second, to determine the specific narcissistic transference involved.

The process by which this occurs involves the use of cognitive skills to locate the specific pathology. In this instance, to paraphrase Racker's analogy, our countertransference feelings are the equivalent of our sense of smell; they can alert us to the existence of a narcissistic personality disorder. Our cognitive skills must be employed to locate the specific disturbance and to verify the initial diagnostic impression.

Thus, in this chapter, clinical material has demonstrated how the therapist's countertransference reactions reflect the patient's projections onto and into the therapist. The actions, awarenesses and experiences of the therapist are influenced by these projections. A specific patient's way of relating to the therapist, if strikingly different from the therapist's usual experience, can affect the therapist's self-perception. Therefore, a therapist who monitors self-experiences during the treatment hour also monitors the way in which the patient is relating. The experience of feeling "not oneself" in a particular session can indicate that the patient's perception of the therapist is quite at variance with the therapist's usual experience, that the patient's perceptions are intense. That information itself can alert the therapist to the possibility of a primitive disorder. The countertransference can be used diagnostically and when so used, heightens

the therapist's ability to tune in to the patient. In order to do so, the therapist must go beyond the recognition of projective identification or even the recognition of neurotic countertransference--for to stop there is to indeed hinder the therapeutic work. What is required is that the therapist sustain the feelings and awareness, study them, cognitively examine them, search for the information they can yield up regarding the patient's internal objects. Under these circumstances, the therapeutic relationship is indeed a healing one, offering the recognition and validation necessary for the task of filling in the deficits of the self.

In this perspective, the questions posed at the beginning of the chapter can be answered affirmatively:

1. Countertransference reactions can be used to identify the presence of a narcissistic personality disorder as defined in self-psychology; and

2. Countertransference reactions can be used to help identify:

   a. The self-object transference as defined in self-psychology and

   b. The nature of the narcissistic deficit of an individual designated a narcissistic personality disorder.

CHAPTER 7

CONCLUSIONS AND IMPLICATIONS

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. The method utilized for this task has involved a coalescence and extension of Kohut's and Racker's works. As a result of this integration it has been possible to suggest through case examples how countertransference can be used diagnostically. Further, an historical understanding was conceptualized as an important and basic facet of the investigation. Consequently an historical and evaluative review of countertransference through the literature has been included.

In its exploration of countertransference as a means of aiding diagnosis, this project is limited to one facet of the diagnostic use of countertransference, viz., the diagnostic use of countertransference specifically with individuals whose symptoms and behavior suggest a basic personality disorder.

This study indicates that countertransference reactions can be used to formulate diagnostic information, to identify narcissistic personality disorders, as well as to

illuminate which sector of the self contains the primary and predominant deficit. More, this project has demonstrated that it is possible to use the therapist's countertransference feelings to diagnose the patient's pathology.

The historical review of the literature discloses that the idea is not entirely recent. Freud (1912) hinted at it when he said that the therapist's unconscious must be used as a sensitive radio transmitter in order to understand the client's unconscious. However, after Freud the focus of interest and attention concerning countertransference turned chiefly to the negative aspects, to the view of countertransference responses as expressions of the therapist's pathology. With that view, emphasis shifted to recognition and elimination of countertransference rather than its use. Though some authors and thinkers in the field (exclusively psychoanalysts in the early years) held divergent views, these had little impact. The prevailing analytic culture idealized the objective observer uncontaminated by feelings or thoughts not under rational control.

Meanwhile, the field of social work had long recognized a precept called the 'conscious use of self' which addressed the way in which the practitioner used personal and emotional reactions in the therapeutic interaction. While the precept was discussed and the principle valued, little was written about how one should accomplish this task. The view of countertransference (for that is

how this author understands the 'conscious use of self') was similar to that held by psychoanalysts: that personal reactions could and would interfere with the progress of the therapy. Little else was said.

The decade of the 1950's brought the beginnings of changes in the prevailing view of countertransference. It began slowly and subtly, yet there were perceptible shifts in the published attitudes towards countertransference. The fifties also saw an increasing broadening of the professional disciplines practicing psychotherapy. What had originally been the province of psychoanalysis, and to a lesser degree, clinical social work, was increasingly joined by clinical psychologists and psychiatrists. These other practitioners tended to understand their roles somewhat differently than did the analysts, and viewed the transference differently as well.

The establishment and rapid growth of mental health clinics brought psychotherapy to an ever increasing segment of the population. As the demand for mental health services increased, so did the need for professionals to provide these services. Training programs were developed. The numbers of mental health professionals who were neither analysts nor trained in analytically oriented concepts increased rapidly. Face-to-face therapy became the norm, and possibly changed the view and expectations of the therapist's role. Further, more severely disturbed people

were seen on an outpatient basis in a therapeutic modality. It was often neither appropriate nor valid for the therapist to adopt the stance of an impartial and scientific observer. During this period, the interactional view of the therapeutic relationship became more prominent. The therapist as a subject of interest came into focus, and a broader view of countertransference began to emerge. The groundwork was laid for the possibility of understanding its diagnostic value.

There are other factors which also may have influenced the changing views of countertransference phenomena. For one, the social changes which led to the upheavals of the 1960's had an impact as well on the field of psychotherapy. Authority was no longer revered as it (so naively) had been two decades earlier. The same thinking that produced the free speech movements, reduced the voting age, and created school advisory councils that included students and parents, also altered the public's view of the psychotherapist. Another important factor may have been the increasing disillusionment with the results of traditional analysis, i.e., its too-frequent failures, increasingly perceived by many educated laymen and professionals alike. Thus, as the infallibilities of authority and analysis were challenged, the value and perceived need of an infallible, objective, controlled observer began to diminish.

Yet another factor may be the simple lapse of time; there were fewer and fewer members of the establishment who had had direct contact with Freud. The disinclination to disturb what he had propounded had probably diminished.

Finally, the field was maturing. It was no longer a strange new pioneer area, ridiculed from without. It had developed both identity and respectability; these allowed self-examination without danger of fragmentation.

Although the shift in the traditional view of countertransference began in the 1950's, there was no clear attempt to use the information diagnostically until the publication of Racker's book "Transference and Countertransference" (1968). That volume presented a model for examining countertransference reactions which, for the first time, enabled clinicians to evolve a disciplined and controlled way of relating countertransference feelings to the patient's dynamics, material and personality. Racker's work was founded on the existence of a dynamic and fluid relationship between therapist and patient. To sustain that relationship, the patient projects his or her feelings and perceptions onto the therapist. The therapist's empathic identifications accept these projections and allow them to be internalized.

Kohut (1959, 1972) postulated that patients who exhibit particular pathologies will leave the therapist with specific self-perceptions. These feelings will be

pathognomonic and can be used diagnostically. Kohut, however, did not explain the mechanism by which this occurred. He seems to believe that the patient's archaic narcissistic deficits arouse, in the therapist, parallel deficits which are never resolved. The therapist's responses thus are related to the patient's pathology. Cognitive understanding of these responses can allow the therapist to continue to practice effectively. Since the therapist's responses are directly related to a patient's transference, they can indicate specific needs of the patient. Kohut's view seems concordant with the traditional one, i.e., that countertransference originates in the therapist's unconscious. By contrast, Racker believed it originates in an identification with the patient. While Racker acknowledged countertransference originating in the therapist's neuroses and Kohut recognized countertransference originating in the therapist's empathic identifications, neither addressed the other aspect wholly. Each investigated one aspect of the total phenomenon, only alluding to the other.

Consequently, this study has also only touched on, but not fully explored, the therapist's neurotic conflicts, how they affect the therapist-patient interrelationship, and whether they can be used diagnostically. Racker (1968) and Kernberg (1975) have suggested that neurotic countertransference has diagnostic value; that it too can tell the therapist about the patient. As may be recalled, this

is markedly different from the traditional view that the neurotic countertransference tells only about the therapist.

How then can one know when one's responses tell about the patient and when not? Kohut (1972) describes one method--the use of supervision-consultation. His view is traditional. In this author's view even those responses which originate in the therapist's intra-psychic conflicts still can give information about the patient. The therapeutic relationship is an interaction and both processes occur. However, this area is one for further research and study.

This project sought to bring together Racker's model with Kohut's idea that the countertransference is related to the patient's pathology. Superficially, the task of combining two seemingly inconsistent theories may have seemed difficult. After all, Racker's concept is developed out of Kleinian theory that the patient will put into the therapist unwanted feelings in order to get rid of them, while Kohut's is based on a process which requires the therapist's empathic identification with the patient. But there is no fundamental inconsistency. Each of the theories complements the other. The two processes form a whole, a complete circle of interactions. One without the other is incomplete.

In this project only one apparent pathological syndrome was examined, narcissistic disorder. This syndrome

results from the patient's incomplete separation from early objects. The patient does not have the experience of firm, clear and definite boundaries. Consequently, the patient-therapist relationship is stickier than it would be were the patient's intrapsychic structure more clearly defined. Whether the countertransference reactions can so be used with individuals who are more firmly structured is not clear. This too is an area for further study.

Implications for Clinical Social Work

The diagnostic use of countertransference requires the clinician's conscious use of self, an activity that is time-honored and valued as a social work precept. It is also an activity that though revered, is little taught in social work schools. It is one of the values by which one school with which the author is acquainted, evaluates its student's performance in the field. It is also a precept without a guiding concept, without standards or norms which can be systematized and taught. No one seems to know how to teach 'conscious use of self' and this is no surprise for it is difficult, analogous to the task of teaching empathy, but more complicated. Teaching this skill requires the examination of countertransference responses which, in turn, approaches therapeutic rather than teaching activity. Social work, as a field, has had difficulty clarifying the differences where they are narrow.

As the literature on countertransference indicates, the ability to use oneself rests on the practitioner's personality, character structure, ability to form identifications and ability to recognize them--the list grows long. It is yet another area for further study--the knowledge of how to identify those components which facilitate the conscious use of self, and explore them. That accomplished, the precept could then be explicated, systematized and taught.

This study focused on clients perceived to be troubled with rather primitive disorders. This population comprises the bulk of patients seen in mental health clinics and community agencies. As previously observed, this population presents with symptoms and behaviors that are frequently difficult for the clinician; they are demanding, critical, withdrawn, non-verbal, angry; rarely pleasant or easy to be with. The extent to which these people can be helped depends upon whether they can remain in treatment and establish a working alliance with the therapist. Compounding this difficulty, the therapist is often limited to once a week therapy, large caseloads, and an increasing set of pressures for short-term work and numerous contacts. In this milieu, it is difficult to work with a patient who leaves the therapist feeling inadequate, angry, non-existent. If the therapist can use those feelings as diagnostic information, the ability to sustain them increases and

work with such patients becomes more effective.

It is this writer's hope that social work clinicians as well as psychotherapists generally, will become more interested in their countertransference reactions, and will provide more clinical data from their own experiences. Awareness of ourselves and our reactions to the patients we see may help therapists to work productively with those individuals who, unable to sustain intimate relationships, are most in need of the vehicle of a therapeutic relationship. Knowing the nature of our countertransference reactions can help us, as clinicians, to accept them non-judgmentally, evaluate them, and then use them to enhance treatment skills.

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APPENDIX A

NARCISSISM AND SELF-PSYCHOLOGY

BIBLIOGRAPHY

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