# GENDER RELATED THEMES OF WOMEN PSYCHOTHERAPISTS IN THEIR TREATMENT OF WOMEN PATIENTS

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# GENDER RELATED THEMES OF WOMEN PSYCHOTHERAPISTS IN THEIR TREATMENT OF WOMEN PATIENTS: THE CREATIVE AND REPARATIVE USE OF COUNTERTRANSFERENCE AS A MUTUAL GROWTH EXPERIENCE

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To my husband Herb and my son Adam. My warmest appreciation and gratitude to both of you for your continuous understanding and support, and for the love and respect you have shown for me and the importance of my work.

## DEDICATION

To the twenty female social work psychotherapists without whom this study would not have been possible. Your gifts of time, enthusiasm, honest self-appraisal, and courage in looking at your own issues and conflicts were unreserved. Your skill, intelligence and sensitivity made me proud to be your colleague and a member of the clinical social work profession. You have my genuine appreciation for your enormous contributions to this study.

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ABSTRACT

Women in contemporary American society cannot avoid internalizing the negative attitudes toward women that have been part of the sociocultural milieu in which they were raised. These attitudes are transmitted and internalized during the earliest phases of a women's development, and within the most intimate framework of object relations. They are then reinforced by the "prevailing culture." The feelings which derive from these attitudes become reactivated in a woman psychotherapist's countertransference, leading to a dynamic interplay with her female patient. The author also posits that a mutual growth process for both patient and psychotherapist can occur if the therapist is open to self-learning through awareness of her own countertransference. In summary, this study describes the nature and content of countertransference experienced by women therapists treating women patients. It also raises the questions: (a) Does the countertransference of the woman psychotherapist have a gender component? and (b) Is a mutual growth and repair for the woman therapist and woman patient possible?

The conceptual framework for this study is drawn from psychoanalytic theory. Freud's theories of female

sexuality (1925-1933) were utilized. Challenges and modifications to Freud's theories as reflected in the contributions of Horney (1924-1935), Schafer (1974-1977), Galenson and Roiphe (1968-1977), and Stoller (1963-1972) were included. The contributions of Mahler (1963-1981) toward an understanding of early development (particularly the "rapprochement" crisis of the separation-individuation phase) form the overall base for this study. Theories of countertransference are discussed from the perspective of Searles (1965-1981), Kernberg (1965), and Racker (1953-1981). Also, recent contributions to female psychology arising out of the early Horner (1965) and Hoffman (1974) studies regarding fear of success are used.

The literature on women's issues concerns many surveys of the attitudes of psychotherapists, but few studies have been based on self-reports by therapists. This study goes beyond the previous merely global surveys to an in-depth exploration of the feelings and conflicts of the therapists themselves.

Twenty analytically oriented clinical social work psychotherapists were the subjects of this study. Criteria for selection included: (1) licensure, (2) sufficient experience to make use of countertransference as an essential contribution to the treatment, (3) current engagement in the practice of psychoanalytically informed

psychotherapy, and (4) past or present experience as a patient in psychodynamic psychotherapy or psychoanalysis.

The author conducted semi-structured, open-ended, in-depth interviews, lasting 1-1/2 hours, with each therapist. Each therapist was asked to present the case of one female patient with whom she had worked for at least six months. The author emphasized that the primary interest of the study was not the treatment itself but the therapist's own countertransference. The interviews were tape recorded and transcribed. They yielded raw data consisting of the self-reports of the therapists. Rich material based on the therapists' conscious inner feelings, concerns, and conflicts was provided by the interviews which were of a consultative as well as cathartic nature. They were intense, emotional, and often described as being "not long enough."

After transcription, the author undertook a line-by-line review of the contents of the interviews. All subjective statements pertaining to the countertransference themes of the therapists were underlined. The therapists' statements were then grouped into columns, one entitled "Major Themes," the other "Secondary Themes."

Five major countertransference themes emerged which were central for the women therapists who took part in this study. The themes included:

1. The therapists' relationship to their mothers, with respect to areas of separation-individuation and identity issues;

2. Their fears of success, as illustrated by their empathic identification with inhibitions, conflicts over ambition, and the devaluing of their own worth manifested by their women patients;

3. Role conflicts, with respect to familial and relational roles versus career pursuits, and conflicts over feminine/masculine stereotypes regarding the role of a professional woman;

4. Envy in their countertransference, related to dependency feelings, and mourning;

5. The importance of the therapists' own life stage, in her conscious countertransference to the woman patient presented.

The five countertransference themes for women therapists are interlocking and ultimately linked to their early maternal experiences. Intrapsychic conflicts are related to sociocultural stereotypes regarding roles which appear to be mutually reinforcing. By virtue of their shared experiences, women psychotherapists build strong bonds with their women patients that offer potential for a mutually reparative experience, provided the therapist works through and maintains awareness of her

countertransference issues. Since some issues are not necessarily resolved in the culture at large, this is not automatically true for all five themes. Four of the five issues appear to have a strong gender-linked component, although a four-celled study of male and female psychotherapists' countertransference to their male and female patients would be required to confirm this inference.

# CHAPTER I

## INTRODUCTION

The most prevalent criticisms of Freud's views on women cite his middle class upbringing in nineteenth-century Vienna. The conventions, constraints, and repressions of that period inevitably colored his attitudes and his thinking. Freud was aware of the fact, and acknowledged that his ideas on female development were open to extensive exploration.

Freud's statement remains glaringly true in our own time. While more progressive than the age of Freud, our own sociolcultural milieu nevertheless presents a dark labyrinth when it comes to theories about women and their development.

Female psychotherapists and their female patients are shaped by the current sociocultural milieu as much as Freud was by his own. Both patients and therapists must deal as best they can with unresolved issues and conflicting attitudes about their femininity and their attempts to balance the social, familial, and professional aspects of their lives.

This is not to say that female psychotherapists are no more capable than their female patients of managing these social and personal issues. Still there are many questions to be posed about women psychotherapists: What are their inner experiences, feelings, and attitudes while working with female patients? During the course of treatment, what is the therapist's self-experience which determines the nature of her countertransference phenomena? In what ways is the therapist's countertransference experience important for both the patient's and her own self-development? These questions are the focus of this study.

Are we to assume that women psychotherapists, owing to the dramatic legal and attitudinal changes wrought by the women's movement, are now endowed with sufficient self-respect that they can help other women to achieve the same? The recent dramatic defeat of the ERA seems to indicate that the answer to that question is no. It was that very defeat which prompted the specific direction of this study--a study which will explore the internal conflicts in women which militate against their deepest needs, ambitions and desires.

The defeat of the ERA was part of a backlash against the enormous efforts of the women's movement and must be given considerable attention. It is this author's contention that underlying the defeat are the deepest,

intrapsychic fears of women--the fear that true equality will radically dissipate their ability to be dependent, and the fear that removing barriers to equality by loosening traditional role definitions may entail what Horner (1968, 1978) and Hoffman (1965, 1971, 1972) in their earlier studies called "fear of affiliative loss."

It is a sobering fact that millions of women supported Phyllis Schlafley, the ultraconservative representative of anti-ERA forces, in her determined and successful efforts to defeat the ERA. We can only surmise that a vast portion of the female population are still living in a dark age in which they are unwilling or unable to recognize their potential for personal achievement in spite of the conflicts inherent in the pursuit of personal growth.

But what are we to say about the relative silence on that score of professional women in social work, psychiatry, psychology, and other disciplines? Few women therapists have expressed concern, and still fewer have expressed consternation, that so many women are so uninformed. Are they fearful themselves, or does a lingering streak of masochism urge them to accept the assumption that they should be content with what they have?

In The Cinderella Complex, Dowling (1981) encouraged women to confront their hidden fear of independence

and the multitudes of ways in which they contrive to remain in a dependent position. Dowling posits that women continue to externalize dependency conflicts, rather than exploring the deep-seated intrapsychic issues which impede their entry into a more productive world.

The literature reveals that many of the studies which have been done about women--their achievements, their successes, and their attendant conflicts--are sociological rather than psychological in nature. Although many are excellent, they mainly attempt to describe the external phenomena of women's lives. For example, Horner (1968, 1970, 1972), Hoffman (1972, 1974), and others broke major ground in directing attention to the enormous sociocul-turally imposed barriers which women experience.

While this author does not intend to minimize the importance of these findings, this study intends to move a step beyond them into a new, vital, and fascinating area of study, and one which Brodsky and Hare-Mustin (1980) believe has been sorely neglected. Since so many women today seek treatment with female psychotherapists, it seems essential to know what inner experiences, feel-ings, and attitudes about women's issues those female psychotherapists possess. One must presume that the depth and extent of these attitudes can profoundly affect the psychotherapeutic process. Thus, one must inquire

about the female therapist's self-experience--her counter-transference--while conducting psychotherapy with women as patients.

The author defines countertransference as the bringing into play, especially but not exclusively in the therapeutic session, any portion of the totality of the therapist's attributes, experiences, and attitudes, through the stimulus of the resonating relationship with the patient. The therapist may reveal her reaction by her speech or demeanor, or by a nuance of facial expression or tone of voice. For the purposes of this study, the author has selected several of the key concepts of Kernberg (1965) ("totalistic" approach), Racker (1968)(concepts of "identificatory processes," "concordant and complementary countertransference"), and Searles (1965, 1978, 1979) ("neurotic countertransference"). These primary concepts will receive elaboration in the Literature Review (Chapter III).

Many observers contend that one cannot live in America and avoid being racist. The seeds of racism are sown so early that, despite considerable education and exposure to progressive thinking, we are still prone to act on internalized racist sentiments. Similarly, no woman in America can totally avoid internalizing the negative attitudes toward women which have been part of

the sociocultural milieu in which she has been raised. These attitudes are transmitted and internalized during the earliest and most formative stages of development, within the most intimate framework of our object relations. These attitudes are simultaneously externally reinforced by the prevailing culture.

The innate paradox of the woman therapist is that she intellectually subscribes to certain notions about liberation, but she has not sufficiently integrated these new attitudes with the residue of her earliest experience. The feelings which derive from archaic attitudes become reactivated in the countertransference, leading to a dynamic interplay with the female patient. Thus, the same female therapist who encourages her female patients, insisting that women have the same needs, rights, and entitlements to creative pursuits, productivity, and strivings as men, may possess unresolved conflicts herself over such issues as familial and professional roles, competitive anxiety, and fears of success. This interplay is a focal point of the study.

The literature on women's issues contains many surveys of the attitudes and feelings of psychotherapists about sex biases, sex-role stereotyping, and about their orientation to psychotherapy. There are very few self-report studies by therapists of their countertransference

experiences. This exploratory study goes beyond the more global surveys to an in-depth examination of some aspects of countertransference and conflicts of female psychotherapists in their treatment of female patients.

## Central Research Questions

There are numerous considerations in the attempt to understand women's psychology [see esp. Freud (1905, 1914, 1924, 1925, 1931, 1933), Galenson & Roiphe (1968, 1975, 1977), and Schafer (1968, 1972, 1974, 1977, 1978)]. A particularly fruitful focus for such an attempt is the exploration of the conflicts and countertransferences of the female therapist. For it is within the treatment milieu that the most intense and dramatic conflicts of women--both therapists and patients--unfold and are reworked in the transference relationship.

Women patients increasingly seek women therapists for their treatment (Applegarth & Galenson, 1975). In the author's view, this does not mean that male therapists lack sensitivity and understanding of women's conflicts. Rather, it reflects women's growing awareness of an absence of early female modeling in assertiveness, ambition, and achievement in a profession or vocation of their choice.

Applegarth and Galenson (1975) found that many women who deliberately chose women as therapists intended to use the therapist as a role model. Thus, it is critically important that women therapists redouble their attention to countertransference feelings which arise in the treatment relationship with their female patients.

The central questions of this study, then, are:

- What are the inner experiences, feelings, and attitudes of female psychotherapists in their work with female patients?
- What, during this psychotherapeutic process, is the nature of the psychotherapist's self-experience, that is, her countertransference?

Two corollary questions are: (a) does gender play a role in these phenomena? and (b) are there possibilities for mutual growth and repair through attention to the countertransference process?

To answer corollary question (a), this study attempts to establish which of the therapist's countertransference feelings and attitudes are idiosyncratic to the therapist's own history, dynamics, and development, and which ones refer specifically to her femaleness and are, thus, gender-related.

Corollary question (b) arose out of a preliminary study conducted by this author, in which five analytically

oriented social work psychotherapists were interviewed concerning transference and countertransference issues between female patients and female therapists. What was most striking in the responses was that each therapist had chosen to discuss a woman patient who, by the therapist's admission, experienced an area of conflict that the therapist shared and sought to understand better in herself. This finding led the author to question whether such therapeutic situations can induce a process of parallel and mutual growth and repair for both the therapist and her female patient.

## Purpose and Significance of the Study

This study is intended as a contribution to the psychoanalytic literature on female conflicts, as seen from the perspective of the woman therapist in her work with women patients. Since the literature has rarely explored the inner experience of the female psychotherapist, the study will provide a more detailed picture of the two-person experience of psychotherapy. It is therefore intended as an additional contribution to the study of female psychology. Since there are few studies which explore the countertransference of psychotherapists by speaking to the therapists themselves, the study is also

intended as a contribution to the literature on countertransference.

Finally, the author also hopes to illuminate considerations for psychotherapists of the potential for growth and learning inherent in constructive use of countertransference feelings in psychotherapy. Awareness of countertransference allows for growth not only in the patient, but also potentially in the psychotherapist. The author, thus, wishes to challenge the concept of countertransference as a "negative" or counterproductive phenomenon in treatment.

## Contribution to Social Work Practice

Because this study focuses specifically on female therapists and their female patients, it is especially relevant for social work practitioners. Women have been predominant in social work since the inception of the field; only in the recent past have the numbers of male social workers begun to increase.

The sheer numbers of female social workers are far less important, however, than the fact that they--no less than the female population in general--have been culturally conditioned and have internalized, unconsciously, or consciously, negative attitudes toward women. Social

workers, like other women, tend to act like second-class citizens, devaluing their own worth, and doubting their contributions.

In her work as a clinician and consultant, the author has been startled again and again to encounter competent social work psychotherapists of considerable reputation who nevertheless depreciated their ability and their contributions, often considering themselves to occupy the bottom rung of the mental health care ladder. Social workers' attitudes about themselves parallel the problems of women's self-esteem which this study will address. As a profession, social work has not demanded adequate recognition for the numerous contributions it has made to the mental health field. It trails other disciplines in achieving recognition for its knowledge, breadth of experience, and valuable contributions to psychotherapeutic treatment.

Social workers experience confusion about their professional identities: the origins of their profession; what it offers; the ways in which it is unique; and how it differs from other professions. To some extent, these are the same kinds of questions asked by all women about their work, especially those in occupations identified as "female." In addition, women social workers must examine their conflicts about being women, just as

their women patients do in treatment. It is hoped that such a double-edged examination may consequently shed light on the special dilemmas of women in social work.

## Organization of the Study

The study has been organized into several sections. This introductory chapter has been presented as an overview of the study, including a statement of the central research questions, the purpose and significance of the study, the contributions to social work practice, organization, limitations, and definition of terms.

Methodology will be reviewed in Chapter II and will include design, nature of the interviews, description of the sample and demographics, and methods and rationale for the analysis of the data.

The review of the literature, presented in Chapter III, covers the major theoretical and conceptual areas addressed in the study:

1. Female psychosexual development and role conflicts;
2. The maternal relationship;
3. Fear of success;
4. Issues of countertransference.

The frame of reference used in this study, presented in Chapter IV, is derived from contributions of the

neo-Freudian, ego-psychology and object relations school of psychoanalytic theory. Aspects of contributions of Kernberg, Racker and Searles on countertransference are considered.

The theoretical framework for this study includes the following major components:

1. Selected aspects of Freud's theories of female development;

2. Mahler's schema on separation-individuation;

3. Galenson and Roiphe's contributions related to female infantile sexuality; and

4. Challenges and modifications to Freud's theories as presented in selected works by Horney, Schafer, and Stoller.

The findings of the study, including illustrative samples of interview data, are presented in Chapter V. The chapter contains an overview of the themes identified through content analysis, and then a presentation of the findings according to the five major themes described in the overview. These include:

1. The therapist's relationship with her mother;

2. Fear of success;

3. Role conflicts;

4. Envy in the countertransference; and

5. Life stages.

Chapter VI contains a detailed discussion of findings from each thematic area; a statement summarizing findings and drawing conclusions; a statement of problems and limitations which emerged during the course of data collection and analysis; and a discussion of practical implications of the study for clinical practice and further research. To the basic data the author has added comments based on her own knowledge and clinical experience. The author has made inferences about several covert themes and issues which she believes to have been part of the self-report data collected in the interviews, and which provide a further elaboration of the findings.

## Limitations of the Study

The most obvious limitation of this study is its restriction to women psychotherapists. It would be informative to explore the question of whether it is true that male therapists undergo analogous experiences with their male patients. Male colleagues have told the author that they learn a great deal about their identity as males from the men whom they see in treatment.

It would also be useful to extend the study of purely gender-related phenomena in psychotherapy to see what new contributions could be made to the understanding of the treatment issues between male therapists and

female patients, and female therapists and male patients.

Another limitation of the study is that the sample of female psychotherapists interviewed are from similar sociocultural backgrounds, and all but one or two are in the same mid-life phase of the life-cycle. Also, the sample of psychotherapists was not randomly selected. Although this homogeneity may supply an interesting focus for the study, it renders the generalizability of the findings open to question.

The study is further limited by the fact that the data are subject to the author's inferences and interpretations. The author acknowledges that the statements of the therapists in the interviews are their own perceptions and descriptions and not necessarily "hard facts." The reader should note that interpretations and inferences of the findings were based on the author's understanding and perceptions of the data, and reflect her interpretative capacities, her understanding of the theory, and her years of experience as a clinician.

## Definition of Terms

### Countertransference

The author defines countertransference as the totality of feelings, experience, thoughts, perceptions, and behavior which the therapist brings to a treatment

session. For purposes of this study, countertransference refers to the consciously-felt experiences of the female therapist in treatment which she reported during the research interview about a selected patient.

Countertransference refers to the feelings, attitudes and opinions of the total person, and reflects the therapist's stage of life; age; life experience; the performance of multiple roles; acute life crises or events; and all separations and losses which affect her internal conscious and unconscious dynamics. The therapist's countertransference, then, is that which she feels toward the patient and within herself. It is a product of the therapist as a total person.

In this study, countertransference refers to the consciously felt and reported inner experiences or feelings of the female psychotherapist in her case reflections about her woman patient. It is also defined to take into account the deeper, more hidden "blind spots," or unconscious, which are a part of the countertransference. These "blind spots" are alluded to by inference of the author.

Repair

As differentiated from the concept proposed by Klein (1937), for the purposes of this study, repair refers to the reworking of certain aspects of the

psychotherapist's life during psychotherapy with a female patient. Repair goes beyond self-knowledge which can also come from the insights gained in the countertransference. Repair refers to the female therapist's actual reworking of aspects of her own life within the selective treatment situation she is describing. Repair is stimulated by the self-discovery, or self-insight, arrived at in the course of therapeutic work with certain patients, but it results in lasting change for the psychotherapist. Repair has a second connotation. It refers to the therapist giving to her patient what the patient has never been given, what is referred to as the repair of a void. As shown in this study, women therapists also give to certain women patients what they had not been given themselves. They are, thus, repairing the void for the patient, and in the process, repairing certain areas for themselves through their own insights acquired within the treatment relationship.

Success

Success is defined as the congruence between a person's ego-ideal and her/his ego-reality. Societal definitions which include professional/occupational achievements, making money, or increasing one's social status, will not be used for this study. Success, here,

is linked to self-perception: one's feelings about and evaluation of one's place in life; one's feeling about one's accomplishments, and one's general sense of satisfaction and well-being, presumed to emerge from the self-perception of how well or badly one is doing according to one's internal criteria.

Fear of Success

The fear of success refers to the specific concepts proposed by the landmark study of Matina Horner (1965). Horner postulated that women avoid and fear success as it appears to them to be contrary to societal role expectations for feminine behavior. In a later study by Hoffman (1974), women were shown to undermine their success because they feared the loss of affiliative relationships.

Role Conflicts

One aspect of role conflict refers to opposing feelings, ambiguities, and ambivalences women have which relate to professional and familial roles. Another has to do with conflicts which women feel about masculine and feminine behavior, as defined by societal role stereotypes.

Envy in the Countertransference

The feelings of the female psychotherapist who wants what her female patient has, or has achieved. It is

important to note that the envy which female psychotherapists referred to in this study was "consciously felt." Thus, in the main, it was understood and dealt with in the therapist's own analysis or analytic psychotherapy. Therapists were quite alert to feelings of envy, lest they intrude upon the treatment of their female patients.

Life Stages

Life stages refers to the tasks, feelings and emotions experienced during the life stage of each therapist in the study. Most therapists in the study were within the age range (38-65) designated as mid-life. This phase of life produces a process of reevaluation and reassessment of one's place in life. It also often produces intense mourning feelings for what has been, what is, and what will never be. Mourning and reevaluation associated with mid-life development became an important theme in this study since these feelings were strongly experienced by a number of the psychotherapists interviewed.

# CHAPTER II

# METHODOLOGY

## Design

The sample includes 20 analytically oriented social work psychotherapists. Each was asked to present a case of a female patient with whom she had worked for a considerable period of time. It was emphasized, however, that the primary interest of the study was not the treatment but the therapist's own self-experience.

The study focused on feelings that were evoked in the therapists by the material that their female patients presented as they struggled with issues relevant to their lives, their dynamics, and with the conflicts and fears which were related to the patients' needs, strivings, failures, and successes.

Each therapist was asked what she believed were the salient themes and issues for herself in treating her female patient. She was also asked to describe in what particular or unique way the patient touched upon or reactivated her own conflicts.

This in-depth interviewing proved to be an extremely productive way to view the "inner experience" of the female psychotherapist as she attempted to help her female patient. The insights it produced--illuminating and sometimes dramatic--are rarely to be found in the more bland and diffuse articles, surveys, and attitudinal scales that describe areas of countertransference and ask female therapists how they view their women patients, and how they view sex differences in their treatment of their patients in psychotherapy.

The 20 therapists were chosen on the basis of their qualifications as licensed practitioners, their having sufficient experience to utilize analysis of their countertransference as an essential contribution to analytically oriented psychotherapeutic treatment, and their having undergone analytic therapy themselves.

The interviews lasted 1-1/2 hours. The first 45 minutes were devoted to the therapist's presentation of her female patient. The remainder of the time was spent in discussion of the therapist's countertransference feelings related to issues that were evoked for her in the course of the treatment with her patient.

Each therapist was asked the same standardized series of questions in order to ensure consistency of the study and comparability of the responses. The questions were:

1. Please discuss one of your female patients, preferably someone whom you have had in treatment for over six months.

2. In what particular or unique way did you feel that this patient evoked feelings in you that may have reflected your own conflicts or issues? What did you feel were the salient themes or issues for you within this treatment of your woman patient?

3. In your view, is there a salient question emerging from this interview that might be especially valuable for consideration by other therapists?

## Nature of the Interviews

It is important to note the quality and ambiance of the interviews themselves. Because of the highly emotional content of the material to be elicited, the author knew from the outset that her role would be far more that of the facilitating interviewer than of the coolly objective recorder of "factual" answers to the three basic questions listed above. And so it proved to be: the interviews were deeply moving, of considerable depth, stimulating, challenging, and difficult to conclude, for both author and interviewee.

The therapists were uniformly open, honest, and self-assessing. When thanked for an extremely sensitive interview, one of them replied:

> I'm glad I was able to give it to you. Your approach made me feel very free and open and enabled me to really share with you in depth. I didn't want it to be superficial because that would have been a waste of both your time and mine--this way I feel enriched by having said it again to someone who could appreciate what occurred in the course of the treatment.

The interviewer chose to conduct the interviews as informally as possible. The interviewer sought a dialogue between two individuals who were interested in discovering ideas and also interested in where their mutual explorations would lead.

Several of the female therapists were reluctant to conclude their interviews; they expressed the wish to go on talking in the same in-depth manner. They felt a mutually appreciative give-and-take. The author gained a great deal from sharing her own inner feelings, and reaped so many personal insights that she virtually felt she had become her own 21st interviewee. The conclusion that women therapists can resonate in a unique way with each other is unavoidable.

A few of the therapists expressed their appreciation for the interview itself, stating that it was like a consultation. They welcomed the opportunity to reflect upon their feelings in their work with the particular patient they had selected. One therapist commented that this was one of the first times she had ever talked about

the particular case she presented. She said, "It's really interesting what's coming up. I'm in touch with a lot that I was not aware of before."

Another wrote to the author some weeks after the interview, "The interview was a fascinating experience and it is having a subtle influence on my treatment of the woman I talked about. She has been difficult but I am now finding I am a little bit freer with her, which I think is having a beneficial effect."

The interviews also aroused powerful emotions on occasion. One therapist grew sad because her dead mother could not see what her daughter had achieved in life, and her mother had always derived enormous pleasure from her children's successes. Many therapists were visibly moved as they expressed their feelings about mothers, mothering, life stages, and particularly the mourning and reevaluations that became one of the major issues for the psychotherapists interviewed.

As the interview began, many therapists asked which kind of case the author wanted them to present, because they often had several interesting choices. The reply was that they should select the one that came most immediately and forcefully to mind, because the choice of a case was likely to be significant in itself. (After all, the case was intended to reveal the therapist's inner life, not to demonstrate her skills or acumen.)

The wisdom of that extemporaneous approach was borne out. Every therapist chose a case that was "close to her heart" and therefore inspired richer and more representative feelings than would have been possible had the choice been more controlled. Realizing this, one therapist observed, "You know, this interview is making me think through something with my patient that is opening up something very important for me." Another reflected, "Until I focused on these issues, I don't think I really saw how much leftover work I have with my mother." At the same time, the therapists expressed obvious concern and conscientious caring for their patients, and the author was convinced that the insights they gained into themselves would enhance the treatment of their patients.

## Description of Sample and Demographics

The therapists in the sample range from 38 to 59 years of age, with one preferring not to state her age. All 20 are psychoanalytic in their orientation to practice; 18 have had or are in psychoanalysis for periods ranging from half a year to 12 years; all 20 have had or are in psychoanalytic psychotherapy for periods ranging from 1 year to 15 years.

Six of the therapists have been practicing psychotherapy for 21 to 25 years, eight for 15 to 20 years, and six for 10 to 13 years. All but one in the sample teach and give supervision to mental health professionals.

Six of the therapists are divorced, 12 are married, 1 is single. Four are childless and 16 have children ranging in age from 2 to 34 years.

## Analysis of the Data

The interviews yielded raw data (consisting of self-reports) providing rich material based on the therapists' inner feelings, concerns and conflicts.

After the interviews were transcribed, the author undertook a careful, line-by-line review of their contents and underlined all subjective statements that appeared to be germane to the issues of this dissertation.

These statements--the raw data--were then grouped into a first column entitled "Major Themes" and another column entitled "Secondary Themes" (see Table 1).

Because the issues often did not present themselves clearly or in uniform terminology, it was necessary for the author to exercise a judgment, make interpretations, and impose uniformity.

Glassman (1975) cites (in a section related to content analysis of the interviews in his study, which

Table 1

Issues and Themes for Female Psychotherapists

| Psychotherapist | Major Themes | Secondary Themes |
|---|---|---|
| B | Theme 1: The Therapist's Relationship to her Mother | Fear of Success<br>Modeling |
| C | Theme 1 | Role Conflicts<br>Envy in the Countertransference |
| K | Theme 1 | |
| Q | Theme 1 | |
| D | Theme 2: Fear of Success | Envy in the Countertransference |
| E | Theme 2 | The Mentor Relationship |
| F | Theme 2 | Female Sexuality<br>The Mentor Relationship |
| M | Theme 2 | Maternal Identification and Repair<br>Role Conflicts |
| N | Theme 2 | Role Conflicts<br>Modeling |
| T | Theme 2 | Maternal Identification and Repair<br>Role Conflicts<br>Modeling |
| I | Theme 3: Role Conflicts | Fear of Success |
| L | Theme 3 | |

Table 1 (continued)

| Psycho-therapist | Major Themes | Secondary Themes |
|---|---|---|
| O | Theme 3 | Maternal Identification and Repair |
| S | Theme 3 | Maternal Identification and Repair<br>Dependency vs. Autonomy<br>Role Models<br>Sex Stereotypes |
| A | Theme 4: Envy in the Countertransference | Maternal Identification and Repair<br>Modeling |
| H | Theme 4 | Life Stages<br>Women's Changing Needs and Values |
| R | Theme 4 | Maternal Identification and Relationship<br>Fear of Success |
| G | Theme 5: Life Stages | Role Conflicts |
| J | Theme 5 | Mourning and Mid-Life |
| P | Theme 5 | Role Conflicts<br>Mourning<br>Mid-Life Evaluation |

generated the primary source of raw data about his subjects' experience of shame) his use of the models of content analysis described by Marsden (1965). Marsden originated procedures for systematically ordering the content of communications. As applied to Glassman's study, these procedures involved dividing the content of the interviews into units, assigning these units to categories, and grouping these categories together in order to synthesize major themes that would characterize his subjects' experience of shame.

Glassman's procedures were adopted as appropriate for the current study. They were used to organize and summarize the masses of information deriving from the subjects' experience. As in Glassman's study, the categories described were grouped together and, as Glassman said, "formed links in a chain of ideas which together will convey a novel and fundamental theme related to the experience" (p. 72). With respect to the current study, the "chain of ideas" related to the therapists' inner experience and, subsequently, the themes or issues significant for the female therapists in the study.

Glaser and Strauss (1967) have developed systematic delineations regarding the theory-building properties and the application of exploratory design. These researchers set forth a phenomenological approach to

discovering theory by purposefully and systematically generating it from qualitative data. Known as grounded theory (because it is grounded in the data), this approach stands in contrast to the logico-deductive approach in which theory is deduced from assumptions. By minimizing preconceived constructs (such as a priori concepts), and by measurement and categorization, an exploratory approach seeks to discover and revise insights, ideas, and concepts in the process of study.

Theory here is regarded as an ongoing and ever-developing process, rather than an end product. Glaser and Strauss argue that generating theory from data provides assurance that the theory will fit and work since it arises directly from the data it describes or explains. Categories or their properties are generated from data; then the evidence from which the categories emerge is used to illustrate the concept.

According to Glaser and Strauss, "Accurate descriptions and verifications are not so crucial when one's purpose is to generate theory" (p. 28). Likewise, the kind of evidence and the number of cases are less crucial in a theoretical study in in a hypothetico-deductive one.

In this study, segments of the data were compared to all other segments of the data to cull out, discern, and describe the criteria that defined the categories,

elements of patterns, and frameworks describing how pattern elements fit together.

Glaser and Strauss (1967, p. 4) regard collection, coding, and analysis of the data, as inseparable. "The generation of theory, coupled with the notion of theory as process, requires that all three operations be done together as much as possible. They should blur and intertwine continually."

This study utilizes the framework described by Glaser and Strauss (1967) in its exploration of the countertransference themes and issues of women therapists.

In order to present a more complete picture of the psychotherapists being interviewed, anonymous demographic material was obtained from them by the use of a questionnaire (see Appendix B, Questionnaire for Psychotherapists).

# CHAPTER III

## LITERATURE REVIEW

Given the vast literature on female development, female sexuality, and women's issues in our society, it is difficult to winnow out and integrate the central issues related to female therapists in the treatment of their female patients. The author has organized the literature around certain frameworks, as follows:

1. Psychoanalytic viewpoints of female psychosocial and psychosexual development. Freud's theories related to female development and female sexuality (1900, 1923, 1924, 1931, 1933, 1937):

   a. Proponents of Freud's theories:

      (1) Deutsch (1925, 1930);

      (2) Lampl DeGroot (1933);

      (3) Bonaparte (1935, 1974);

   b. Modifications of, and challenges to, Freudian theories, and more recent contributions to the literature on female development and issues of role conflicts:

      (1) Schafer (1974-1980);

      (2) Horney (1926, 1933, 1935);

      (3) Jones (1927, 1933, 1935);

      (4) Galenson and Roiphe (1971, 1975, 1977);

(5) Stoller (1963, 1965, 1972);

2. Contributions from the theories of Mahler (1964, 1968, 1970, 1981) on the maternal relationship, especially separation and individuation and their significance for female development;

3. Fear of success, as elaborated in the work of Horner (1965, 1970), Hoffman (1974), and within the bio-cultural area, the work of Bardwick (1976), etc.

4. Issues of countertransference as reflected in the works of:

a. Kernberg (1965);

b. Racker (1953, 1968, 1981);

c. Searles (1965, 1978, 1979).

The works of Freud, Mahler, Galenson and Roiphe, and Schafer form an over-all framework, and will be regarded as central to a consideration of each of the issues stated. In addition, there are numerous contributions of psychotherapists and psychoanalysts which conceptualize issues in the treatment milieu with the woman patient, including but not limited to: Miller (1973, 1976); Kirkpatrick (1972); Fabrikant (1974); Brodsky (1973, 1980); Schecter (1979) and G. Friedman (1980).

There are numerous contributions in the literature from the field of social work which pertain to women's issues, and women in psychotherapy. Several of these

studies are articles have been utilized for this study. Most noteworthy are the studies of Allphin (1982), Grayer and Sax (1981), Smith and Smith (1981). Others not cited in the study were also used as references.

Despite the copious literature, including surveys of the attitudes and feelings of psychotherapists with regard to sex biases, sex-role stereotyping, and approaches to psychotherapy, few studies explore the issues and conflicts which female psychotherapists experience in their work with female patients.

## Female Psychosexual Development and Role Conflicts

Kleeman (1977) says that some of Freud's ideas require correction and modification because of new information from a variety of sources, including the direct observation of children. Direct observation can expose the researcher to direct manifestations of early female sexuality which can only be inferred from reconstructions in adult analysis. Several who have subjected phenomena to direct observational study are Stoller (1968, 1972), Galenson and Roiphe (1971), and Kleeman (1975).

Freud's conception of women met an immediate flurry of challenges from Horney (1926-1933), Jones (1927, 1933, 1935), and Klein (1932). In support of Freud's view were Lampl DeGroot (1928, 1933), Deutsch (1934), and Bonaparte (1953). Erikson (1950) and Greenacre (1945, 1948, 1950,

1952, 1953, 1958) also made significant contributions to the understanding of infantile sexuality and femininity.

One of the two important new points in Freud's paper "Female Sexuality" (1931) was his discovery of the strength and duration of the little girl's preoedipal attachment to her mother (1925): "We see . . . the phase of exclusive attachment to the mother which may be called a pre-oedipus phase, possesses a far greater importance in women than it can have in men." (p. 221)

His general stance is that the path to development of femininity does not lie open to the girl until she has passed through the phallic phase, the observation of anatomical difference, the castration complex, a sense of inferiority, and penis envy, and has entered the Oedipal period, turning from her mother toward her father. He declared in "Three Essays" (1905) that the young girl is ignorant of her vagina until puberty. He retained these ideas throughout his writing from 1908 to 1940.

Freud (1925) considered that penis envy is a phenomenon which can be observed very directly in little girls. He attributed it to the girl's envy of anything more than she had, together with the supposition that she had a less adequate organ for masturbation and was not equipped to carry out her phallic strivings with her mother. He has told us little about the factors which influence the outcome of

penis envy, i.e., whether it takes a normal direction and is more or less submerged, or takes a pathological turn toward the masculinity complex with homosexuality as its extreme.

Freud (1924) further stated that the absence of a penis was compensated for by the fantasy of having a baby, later realized in fact. Other analytic writers of the time, most notably Horney (1924, 1967) and Jones (1927, 1933, 1935), took issue with Freud's explanation of penis envy, though not with his observations. Horney heavily emphasized the effects on the little girl of the vastly superior position, both in valuation and powers, enjoyed by the boy and man in the family and in society at large. In addition, she pointed out how many more restrictions were placed on the girl's instinctual life, both sexual and aggressive. The girl's envy, she explained, would tend to center on the penis itself because that was the significantly different feature which, to her mind, would explain the different way she was regarded. Horney felt that initial penis envy was strengthened to the degree that the heterosexual wishes of the Oedipal phases were regarded as especially dangerous and, therefore, retreated from in the form of envy, or the wish to be a man instead.

Today, whatever one's theories about female sexuality, more stress is laid on the importance of identifications,

various ego and superego factors, and the influence of family and society in general. This contrasts with Freud, who maintained that masochism was truly feminine (1933) and developed the idea of the active element in the little girl's attitude toward her mother and toward femininity in general (1931). Nevertheless, Freud was not unaware of the impact of society on development.

The missing link in Freud's work was gender identity. The study of gender identity has prompted a major correction of Freud's theory about early female sexuality (Greeson, 1956; Kleeman, 1971; Money, 1965; Stoller, 1964). First came a gradual shift by a few analysts away from Freud's point of view that there is no femininity until the phallic phase or later (Greenacre, 1945, 1952; Horney, 1933; Jones 1933, Zilbourg, 1944). Freud's assertion that there was no femaleness until puberty was based on his assumptions that masturbation was essentially all clitoral and the clitoris was a little penis.

The answer to the question of when femininity begins would seem to rely on a study of the origins of the little girl's gender identity. Studying how a girl acquires her sense of being female (the early phase of which we call core-gender identity) by a variety of methods, including direct observation of children, reveals that the assignment of gender at birth is a crucial moment. One cannot

understand the role of gender identity without giving proper credit to the moment of assignment, which, in turn, sets in motion a whole process of acculturation teaching the little girl that she is female, and what and how a female is supposed to think, to feel, and to act like in the family, and in the segment of society that family represents (Stoller, 1963).

Taking a cognitive-developmental approach, Kohlberg (1976) presents the point of view that, at a very early age the key to early gender identity may be found in the maturation of cognitive capacities. The child's conscious and not-so-conscious labeling of herself as a girl, which progresses as her cognitive apparatus matures, serves as the primary and basic organizer for subsequent gender experience. According to this view, even identification processes, which psychoanalysis has emphasized in gender-identity formation, would be secondary to this labeling which continues throughout life.

Schafer (1974) presents the most formidable challenge to Freud's views of female psychology. Schafer sees ego psychology as the proper subject of a psychoanalytic study of the whole person, the individual who develops and lives in a complex world. All aspects of development, he says, must be profoundly influenced by learning in the context of object relations that are, on the one hand,

biologically essential and biologically directed, and, on the other hand, culturally molded and historically conditioned. Schafer urged his readers to rethink the concept, as well as the role of penis envy, in female development.

Schafer further focused on some of the problems he saw in Freud's theoretical generalizations concerning women's development and characteristics, and he attempted to examine the logic and internal consistency of Freud's ideas. Schafer points out that Freud reverted to his earlier simpler and patriarchal viewpoint (1923, 1925) from which female development seems to be both second best and second rate; Freud was never able to consolidate and develop a fundamental change in this regard. From this fact follow many of the problems in the psychology of women.

Regarding women's morality and objectivity, Schafer questioned that Freud had characterized women as less moral than men. Schafer felt that Freud had confused values and observations. He dismissed as nonsense Freud's generalization that obsessive natures (masculine) are more moral than hysterical natures (feminine). There were two reasons for Schafer's conclusion.

In Freud's final theory of development, castration anxiety is the chief incentive for the renunciations and

identification that constitute the influential superego identification (1923). Freud concluded that girls, already believing themselves to have been castrated, lack the same incentive as boys to become moral. Consequently, they seek solace and restored self-esteem in being loved by men and receiving babies from them (1925).

Schafer believes that Freud clearly did not appreciate the part played in the girl's development by the active, nurturant mother who had her own sources of pride and consolation. In addition, Schafer stressed the role played by the great variety of environmental influences and emphases about girls and women.

When Freud cautioned against overestimating the degree of true superego formation of people in general, one can presume he meant men in particular. But in his psychoanalytic writing, Freud did not sharply distinguish between superego and moral code. One such consequence is a radical alteration of the idea of superego, for now it is understood that superego is not morality at all, nor can morality grow out of it alone. Superego is fierce, irrational, mostly unconscious, vindictiveness against oneself for wishes and activities that threaten to bring one into archaically conceived, infantile, or dangerous situations (Schafer, 1974).

Freud may have drawn exactly the wrong conclusion from his theory. If, on account of her different constellation of castration concerns, a girl does not develop the implacable superego that a boy does, than at least in this respect, she might be better suited than a boy to develop a moral code which is enlightened, realistic, and consistently committed to some conventional form of civilized interaction among people. If taken as truth, this concept forms the basis of another widely held view of women which Freud ignored in his theory: women as the guardians of civilized conduct and morality (Gilligan, 1982).

Schafer (1974) says:

> Any psychological approach to the pre-phallic period must center on the girl's primary, intense, and ultimately indestructible relationship with her mother. Freud was mostly concerned about the girl's turning from her mother to her father as lover and sire of her children. In this effort, he portrayed the girl as simply having turned against her mother and against her own identification-based active orientation and her clitoris. To be consistent with psychoanalytic propositions and findings, one must see the girl and the woman as in a profoundly influential, continuously intense, and active relationship, not only with her real mother but with the ideal and imagined presence of her mother and with her identification with this mother. One must also see her as integrating her clitoris firmly into her sexuality. Whatever the girl's narcissistic vulnerability at the time of the castration shock, it has its history and its meaning in this matrix. Although Freud approached this consistency in some of his later papers he did not achieve it. (p. 476)

The Emergence of Role Conflict

Applegarth does not disregard the problem of the legitimate competition between the demands of motherhood and career, which remain as a complex amalgam of real and internal forces. Many women who wish to pursue work are tormented by guilt, feeling that proper mother-love does not permit the straying of attention from children. Others may suffer echoes of their own separation anxieties as children and hesitate to be away from their own children lest something harmful befall them. All of the woman's identifications with her parents come to the fore and produce additional complications.

As a clinician, one can see that such obstacles present formidable resistances to exploring inhibition in achievement and also to uncovering women's strong feelings of inferiority. The therapist's effectiveness in treatment rests on dealing with this resistance, no matter what one decides to do, as a private citizen, about the realistic outside obstacles.

Veroff (1969) feels that the development of achievement motives in girls requires a somewhat rejecting attitude by the mother when the girl is young, an appropriate timing of stress and mastery when she is in middle childhood, her acceptance of the appropriateness of female achievement, and a female role model who is not too strong or domineering.

Girls should also not have experienced too strong an emphasis on interpersonal gratification during early childhood.

Bardwick (1971) thinks that the critical factor is the development of an independent self and an independent motive to achieve. Alienation from parents is probably insufficient by itself to account for the achievement motive. The women who are most professionally committed have a feeling of independence, internalized criteria for esteem, and enough social alienation to be able to defer marriage until they have prepared themselves for their future vocations. In discussions with women Bardwick found that a common theme which emerged for high achieving women was their perception of the futility or emptiness of their mothers' lives, especially after the children were grown and gone.

## The Maternal Relationship

The process of separating and individuating the self is a dynamic one and ongoing throughout life. Similarly, the process of discovering oneself and one's identifications as a woman is derived out of the ebb and flow of life, and the process of movement and return, in memory, to one's mother. This, of course, is not so much in the actual sense, but in terms of the reconstructions and reworkings in life,

as well as in psychotherapy, of selective aspects of one's identifications.

Friedman (1980) points to new discoveries yet to be made in the mother-daughter relationship. She believes there is something in the separation and identification process between mothers and daughters that makes the daughter's struggle for independence, and for a sense of herself as a woman, so difficult to achieve.

Mahler (1981) reflects upon aggression in the service of separation-individuation, commenting that the difficulties of resolving mother-daughter conflicts in the pre-Oedipal, Oedipal, and post-Oedipal realm are evident. She points to the difficulties women, in particular, experience in achieving separation-individuation and differentiation from their mothers. She observes:

> When separation from the postsymbiotic mother becomes a necessity, the boy has the father to support his attainment of personal and gender identity. Under ordinary circumstances, the father offers uncontaminated personality traits, traits in particular which fit the gender identity needs of the boy. The girl also has to disidentify herself from part-object representations of her mother, and goes through a tortuous and complicated splitting, repressive, and reintegrative process to attain and maintain her self and gender identity. (p. 827)

Kramer (1978) reflects on the technical significance and implications of Mahler's separation-individuation theory. She reviews the two main sources of developmental concepts:

reconstructions from psychoanalysis of adults, and direct observations of young children. The most ambitious undertaking have been Mahler's longitudinal, psychoanalytic, observational studies of earliest development, including parallel studies of psychotic and normal children.

Mahler's symbiosis-separation-individuation theory, which derives from clinical practice as well as observation, is much more than an object-relations theory. Her theory adds to theories of ego functions, and to the theory of drives. It deals with basic moods, addresses the vicissitudes of infantile omnipotence as well as of depressiveness, and describes the complex and vital structuring, in much detail, of object and self from the undifferentiated child-mother symbiosis to the attachment of object- and self-constancy (see also, Jacobson, 1954).

Mahler stresses the need for the analyst or the psychotherapist to be cognizant of pre-Oedipal influences, more comfortable with countertransference, able to tolerate and to understand the patient's immature and aggressive needs, and able to use separation-individuation theory as a framework for the analysis of the patient's pre-Oedipal conflicts.

Mahler (1975) describes the rapprochement subphase toddler's "warding off" pattern directed against "impingement upon . . . recently achieved autonomy," adding that, "autonomy is defended by 'no' as well as by increased

aggression and negativism of the anal phase." (p. 77) The source of aggression is the growth process and all the mechanisms of life itself, as Greenacre (1960), Spitz (1953) and Winnicott (1965) have implied and explicated.

Even the most clinging and symbiotically unsaturated infant takes his first unaided steps away from, not toward, the mother. Often the first steps are taken in the mother's absence. In the normal infant, from the differentiation subphase on, the distancing and disengagement phenomena complete with the appeal and the approach behavior, i.e., a kind of alternating behavior prevails, which is best characterized by the term ambitendency (Mahler, 1975).

Ambitendency is built into the task of the ontogenetic achievement of separation-individuation. The impetus of the constructive aggressive momentum by which the infant builds his or her own individual identity is dependent on the mother's libidinal availability as home-base for a long, long time. The infant's autonomous functioning requires the unintrusive facilitating presence of the mother for its optimal unfolding, especially in the course of the practicing period of the separation-individuation process (Mahler, 1981).

Friedman (1980) focuses on an essential factor in the successful emergence of the adult woman, namely, the establishment of a loving bond between mother and daughter.

A painful aspect of this task is for the mother to facilitate the separation process, to stand back and permit it to happen, in fact, to encourage it. This is a painful process for both mother and daughter as they struggle to become independent of each other.

Friedman refers to the anxiety activated by the separation process which often, (due to the feelings about loss and change) is incompletely or unsatisfactorily resolved. The awareness of mother and daughter of their separation contributes to its painful and disruptive quality. Daughters have the paradoxical and difficult task of introjecting and identifying with the very person from whom they must separate. By contrast, boys have the advantage of identification with the father.

Mahler speaks of "identification" with mother not as core gender identity, i.e., "I am a girl," which seems to be established fairly early with the beginnings of speech. Core gender identity refers, instead, to the complex definitions and attributions of the female self that each daughter slowly evolves over the years.

Friedman says, "As we listen to women, daughters all, however diverse their problems, their struggles to be independent and successful in their roles as women ultimately become focused around their relationships with their mothers." (p. 92) Only when the wish to claim her identity, her

womanhood, emerges does it become clear and urgent that conflicts in separating from the mother become intensified and stand a chance of being resolved. The mother's reactions are crucial to the eventual resolution, that is, the mother's ability to share her womanhood, while at the same time giving support and approval to her daughter's emerging independence. Otherwise, the mother may feel abandoned and threatened by the process of separation, disapproving of, competing with, or in some sabotaging her daughter's efforts.

Solnit (1973) speaks, although with reference to younger children, of the need for a continuity of affectionate bonds in order to achieve autonomy. This bond is a two-way relationship based on a common identification and a deeply felt association. He postulates that this bond is a necessary and vital connection, different than dependency, and hence not something to be severed, but rather fostered and consolidated.

Friedman (1980) links fear of success to difficulties in separation and individuation, noting that patients who manifest classical, Oedipal wishes and guilt begin to reflect, in dreams, fears of success. The themes which emerge involve feelings of being isolated and alone, being bad if one succeeds and achieving selfhood as a disloyal act. Dreams in which the therapist betrays the patient

by rejecting and disapproving of her, lead the patient to awareness of her fear that the therapist (mother) would not want to share her own capabilities as a woman. The patient's conviction is often that if she is different or holds unique ideas, she will give up the link. Thus success will have, in fantasy, cut her off from her family and from her therapist.

Parnell (1978) explored relationships between mothers and daughters related to self-concept and role concept. One of the most interesting findings of Parnell's study was that androgynous mothers have daughters who describe themselves as feminine and traditional, while feminine mothers have liberated daughters. Thus, daughters may react to their mothers by being different. Although pro-feminist mothers tend to have pro-feminist daughters, this similarity is an exception. The definition of femininity was explored as it changed generationally, as were other sex role stereotyped adjectives.

Smith and Smith (1981) reflect on the dimensions of the mother-daughter relationship, holding the spotlight on the daughter's need to revisit her relationship with her mother in order to explore her own identity and reexamine her own role.

Smith and Smith feel that every mother contains her daughter in herself, and every daughter, her mother. Every

woman extends backward into her mother and forward into her own daughter. The conscious experience of these ties produces the feeling that a woman's life has spread out over generations.

Smith and Smith see the orchestration of these themes in the transference and countertransference. In the microcosm of therapy, all may be seen to be working in concert. Their basic assumption is that the way one has been mothered profoundly influences the way one will mother, and determines, to a marked degree, how one "mothers" professionally. They identify self-knowledge and training as great equalizers, although they neglect a specific reference to the value of psychotherapy as a vehicle for accomplishing the former. They state: "For a therapist, the work of sorting out the mother-daughter relationship is never complete. The mother becomes old, or the daughter becomes a mother, and all of this will mean that the mother-daughter relationship will need revisiting, especially at times of passage. This is a continuing dialogue in the service of rapprochement." (p. 66)

Lebe (1982) stated that in a girl's psychosexual development there is a fostering of prolonged dependency. For this reason, Lebe speculated that the ages between 30 and 40 may be the normal period for women to resolve their individuation. She defines individuation in adult women as the completion of the separation-individuation process

from the mother, culminating in the ability to positively identify with the mother or positive mothering person, and, hence, the ability to accept their femininity, thereby resolving the Oedipus complex.

Because of the complexities of the psycho-sexual development in females, most women incompletely resolve their oedipus complex. They tend to only partially separate from the mother by idealizing their fathers, and other men; they remain dependent upon the man's strength, support, achievement, and power in a way that inhibits their own sources of assertiveness and creative expression. This reaction is considered normal and healthy femininity by many psychoanalysts, as well as by society in general. Lebe views this, however, as an incomplete resolution of the Oedipus complex, preventing women from competing actively and fully with men because of the residual fear of castrating men and being ultimately forced to regress to the omnipotent mother.

As there is sufficient distance from the pre-oedipal, omnipotent mother by the time most women reach their 30s, this is the ideal time, developmentally, for women to most successfully resolve the separation from mother and the oedipus complex. By this time, the woman's original internal object representation of her omnipotent mother has been modulated. A woman has had time to achieve in school,

career, marriage, and the community. She often has had children of her own. All this builds her self-esteem (Lebe, 1982).

Passive dependency in women is not a mature adult state, as several authors hold, but rather a partially resolved individuation from the mother now transferred onto men. In becoming attached to men and idealizing them, such women de-value themselves in order not to regress to the omnipotent pre-oedipal mother. Adulthood (30 to 40 years) is the time when this resolution can occur because there have been sufficient narcissistic achievements for the woman, enough distance from the actual pre-oedipal mother, and an opportunity to observe that her own anal-sadistic impulses toward men have not castrated or destroyed them. She is also able to see men as fallible and human. This is a reason why so many women return to school or begin careers in their 30s (Lebe, 1982).

Stoller (1968) states that although biological forces can change gender behavior in animals, these fundamental qualities in men and women are shaped by quite non-biological forces. Family psychodynamics help to shape gender identity in infancy. In an earlier paper entitled "The Sense of Femaleness," Stoller (1963) writes that the sense of being a female develops out of the same roots (parental attitudes an ascription of sex, genitalia, and a biological force) as

does the sense of being male, and this core gender identity persists throughout life unalterably in women as in men.

Stoller supports those who believe that Freud may have distorted his whole description of the development of sexuality in both boys and girls by his insistence on beginning the story, in certain regards, only after the onset of the phallic phase. There is evidence that what Freud considers the first phase of gender development in a little girl is in fact a secondary phase, the result of a growing awareness that there are people whom the little girl is, in fact, thinking luckier than she, whom she recognizes as belonging to the classification of "male."

Stoller (1963) states that it seems well established:

> That the vagina is sensed, though probably not eroticized in little girls, yet I believe that it is not the essential source of femininity. From observing little girls they show definitive signs of femininity long before the phallic and oedipal phases and one can trace the early trace of femininity from at least the first year or so of life, not ever seeing them disappear as the little girl grows up and becomes mature. If this observation is correct then this fundamental building block in Freud's theory in the development of femininity--penis envy and castration complex--becomes only one aspect of the development rather than the origin of it. (p. 48)

He suggests, however, that the earliest phase of women's femininity--core gender identity--is the simple acceptance of body ego, "I am female." Only later will this be covered over by penis envy, identification with males, and the other

signs of femininity in disrepair with which analysts are so familiar.

Ogden (1978-1979), in "A Developmental View of Identifications Resulting from Maternal Impingements," attempts to understand in early developmental terms patients who demonstrate a powerful identification with the maternal pathology.

Winnicott (1945, 1948, 1958), approaches the area of internalization by his insistence that the early development must be viewed from the context of the mother-child diad. If, instead of empathically responding to the infant's spontaneous gesture, the mother substitutes something of her own, the continuity of her infant's rudimental internal self is interrupted. The infant learns to defend him- or herself against such "impingements" by prematurely developing defenses that help him/her to perceive and comply with the demands and needs of the mother.

Greenacre, in her work on focal symbiosis (1959), discusses a "peculiar union of the child's special need and the mother's special sensitivity," and brings to life the way being the object of a projection (a projective identification) of this kind involves a special "fit" between two people, giving each the feelings of being crucially important to the other. (p. 620)

## Fear of Success

Horner (1965, 1971) conceptualized the motive to avoid success as an internal psychological representation of the dominant societal stereotype which views competence, independence, competition, and intellectual achievement as qualities basically inconsistent with femininity, even though positively related to masculinity and mental health. Broverman, et al. (1968, 1970) found that young men and women tested over a period of years tended to evaluate themselves and behave in ways consistent with the dominant stereotype. The expectation that success in achievement-related situations will be followed by negative consequences arouses fear of success in otherwise achievement-motivated women which then inhibits their performance and levels of aspiration. (p. 158)

Freud (1933) equated the essence of femininity with the repressed aggression which is imposed upon women by their constitutions and by society and Mead (1949) further alludes to this phenomenon by reflecting: "Each step forward as a successful American regardless of sex means a step back as a woman." (p. 14)

While Horner highlighted the idea of the psychological barriers to achievement in women, Maccoby (1963) had already pointed out that girls who maintain the qualities of

of independence and active striving necessary for intellectual mastery defy the conventions of sex-appropriate behavior and must pay a price in anxiety. Thus, although our culture and educational system ostensibly encourages and prepares men and women identically for careers, the data indicate that social, and, even more importantly, internal psychological barriers rooted in this image limit the more attractive opportunities to men.

In her clinical practice with women, the author has viewed not only the motive to avoid success but also, if success is attained, the attempt to hide it. Similarly, in the early Horner studies (1965, 1968, 1971), successful female students preferred not to divulge the fact that they were doing well, particularly to male peers, but willingly made their failures known. Many young women reported changing their future career plans toward what they considered more traditional, appropriately feminine, less ambitious careers. Thus, to be less ambitious, less aspiring, and to enter occupations reflecting a more feminine direction would be less anxiety-producing.

Horner's conclusions still ring true, in the present decade:

> There is mounting evidence suggesting that many achievement-oriented American women, when faced with the conflict between their feminine image and developing their abilities and interests, disguise their ability and abdicate from competition

> in the outside world. When success is likely, or possible, threatened by the negative consequences they expect to follow success, young women become anxious and their positive achievement strivings become thwarted. In this way, their abilities, interests and intellectual potential remain inhibited and unfulfilled. (p. 171)

Horner acknowledged that the psychodynamic causes and consequences of these differences are among a number of yet-unanswered questions.

Hoffman (1972, 1974) continued the exploration of fear of success by concluding that women feared success because they feared affiliative loss. She reviewed child developmental studies to shed light on female achievement motives, suggesting that females have high needs for affiliation which influence their achievement motives and behavior, often blocking them. Girls, she believed, receive less encouragement than boys for independence, more parental protectiveness, less pressure for establishing an identity separate from the mother, and less encouragement toward independent exploration of their environments. Furthermore, the separation of the self from the mother is delayed for the girl because she is the same sex and has the same sex-role expectations. Hoffman feels that girls do not develop confidence in their ability to cope independently in the environment and, therefore, retain their infantile fears of abandonment. Safety and effectiveness lie in affectional ties.

Baumrind and Black (1967) and Baumrind (1971) indicate that competence comes not from permissiveness but from guidance and encouragement. The mother's delight is part of her child's training for independence; her apprehension constitutes training in dependence.

Horner and Hoffman opened important doors to the study of women's inhibitions and fears of success. They also left open questions that required a deeper penetration into the origin and extent of women's intrapsychic fears and barriers.

Galenson (1977) wrote on the phenomenon of "examination anxiety" in women, exploring a puzzling feature of female psychology, namely, the fear of competition. This fear has been recognized as far more common a problem for women than for most men. Galenson studied a group of young, ambitious, and intelligent women patients, all of whom were involved in graduate study programs and presented strikingly similar clinical features in relation to impending school examinations. Their symptoms revolved around several major anxieties: fear of object loss, guilt and self-reproach, deep concerns about bodily integrity, and anxiety feelings of intellectual imperfection. Further, another feature was the eruption of intense sado-masochistic fantasies which interfered with their usual capacity to enjoy sexual relations and masturbation. The examination itself was perceived unconsciously (as reflected in dream material)

as a sado-masochistic attack. The exam would show them up as stupid and imperfect, and they feared losing control by bursting into tears or having to urinate or defecate during their exam.

Under the pressure of impending examinations, several patients showed the pull of regressive wishes for an earlier dependent relationship as a way out of the competitive showdown. The predominant transference was of an intensely maternal nature. Oral demandingness, rage, and rather acute depressive states, often with hostile ambivalence, subsided once exams were over (Galenson, 1977).

Applegarth (1970) believes that the degree of doubt about their capacities in comparison to others is of a different order of magnitude in women than in men. She links this difficulty in self-esteem with the problem of penis envy in women, emphasizing that the conviction of their own female inferiority is extremely firmly held, as Freud discussed in "Analysis Terminable and Interminable" (1937).

Galenson (1977) believes that the examination anxiety in women whom she has treated is dynamically and genetically different from the same symptoms in men, a difference which has considerable significance in regard to the more general problems of fear of competition and self-esteem regulation in women. The difference stems from the divergent lines of

development in the two sexes, beginning in the latter part of the second year of life.

During this early genital phase, attributes and qualities connected with maleness and femaleness begin to be slowly integrated by the child. This includes the primary cathexis of the genitals and the genital anatomical difference which affects other sectors of development-object relations, drive organization, and many aspects of ego functioning.

The data of Galenson and Roiphe (1968) lends support to Freud's (1933) statement that "The discovery that she is castrated is a turning point in a girl's growth." However, they felt this discovery takes place at an earlier age than Freud indicated. The subsequent sense of loss may be profound to only moderate, depending upon many factors such as the quality of the child's tie to mother, earlier bodily experiences, the availability of the father at this time, and the mother's conscious and unconscious attitudes.

Galenson and Roiphe believed that these castration responses to the sexual differences are important organizing influences from this time onward (Galenson & Roiphe, 1971, 1974; Roiphe, 1968; Roiphe & Galenson, 1973) and determine not only the direction of the girl's subsequent

psychosexual development, but other aspects of her personality, both in an enhancing and inhibitive way.

Galenson and Roiphe's work is clearly relevant for women patients and their women therapists as it relates to inhibitions, sexual and competitive anxiety, and prohibition of actualizing efforts. They cite the effect of the early castration reactions of the pre-oedipal girl upon her developing object ties. In addition, in regard to the clinical syndrome of examination anxiety Galenson (1977) stresses the fact that,

> Early castration reactions take place precisely during the era when intellectual functioning has begun to assume some characteristics of secondary process thought. Various pre-symbolic forms, such as gesture and semi-symbolic play are developing during the second year of life, and speech is just emerging. The new symbolic function is utilized in the child's expanding knowledge of the world. It is also utilized, however, for the expression of thoughts and affects. It would appear, then, that the budding intellectual function is involved, in many little girls, with their concern over genital intactness, as well as the older renewed anxieties of object and anal loss. It is not surprising to find, then, that the intellectual function is perceived by many, if not all, women as phallic. (p. 17)

The option of choosing a career conflicts with heterosexual attachments. Intellectual competition with men must be reconciled with the feminine role in a love relationship by those women who wish to pursue a professional career.

On the basis of her own clinical work, Schecter (1979) reconstructs the developmental psychodynamics of the fear of success syndrome ("success phobia") in women. She points out that the conflicts, inhibitions, and anxieties of this syndrome, success phobia, are seen clinically as symptoms of intense anxiety, marked ambivalence, inhibition of assertion, phobic avoidance of conflictual areas, depersonalization, detachment, isolation, and emergence of psychosomatic symptoms.

Schecter describes patients who express fears of failing, as well as fears about being the object of criticism, humiliation, and shame. These patients are unable to experience any joy or pleasure in success, other than transient highs. They become aware of self-defeating masochistic behavior such as sabotaging their own success. Attendant upon their success, incapacitating depression may set in. Schecter portrays these patients as in mourning, communicating some version of the following message: "Now that I have everything, what I always wanted, I have nothing." (p. 34)

The literature on this syndrome in both men and women focuses primarily on the assumption that the syndrome is derived from conflicts rooted in the Oedipal phase of development (Freud, 1916). Success is perceived as taboo because it is equated, unconsciously, with aggression of

women is considered by Chasseguet-Smirgel (1970) to be associated with "a freeing of guilt toward the father, a guilt which is specifically feminine . . . For both sexes successful intellectual activity is the unconscious equivalent of possessing the penis." (p. 106) For the woman, this implies castration of the father, in addition to dispossessing the mother. Inhibition in creativity, is assumed to have a phallic significance.

More recently, attention has been drawn to the woman's unresolved dependency conflicts with the mother (Moulton, 1977; Symonds, 1971, 1976). Cultural factors have also been stressed, beginning with Horney (1935), Thompson (1941, 1942), and Mead (1949). These studies underscore the woman's fear of departing from the culturally reinforced prototype of the passive-dependent female. In addition, the current cultural ego-ideal for the successful woman no longer fits this description. Traditionally, such character traits as passivity, dependency, submissiveness, etc., have been elevated to the status of a prohibitive aspect of the cultural ego ideal for the successful woman.

In her psychodynamic reconstruction, Schecter reflects that the women in her study are not primarily "victims" of societal discrimination or products of oppressive cultural conditioning. Despite optimal or favorable external

conditions, there have remained severe internal obstacles in the area of achievement and success. Psychic reality has not reflected external reality, and a facilitating environment could not be utilized, even when present, because these patients have unresolved, unconscious, intrapsychic conflicts with a developmental history.

Schecter (1979) argues that the key to the nuclear conflict in many women with this syndrome is that success is unconsciously perceived as causing a breach in the primary dyadic bond with the pre-Oedipal mother:

> The ultimate fear is that success threatens the women's very survival by anticipation of retaliation from the pre-Oedipal mother in the form of total abandonment, a severance of the mother-daughter bond . . . what seems to get stirred up is the original primary intrapsychic bond with the internalized object, the omnipotent mother. The actual relationship with the mother may or may not enter the picture. (p. 35)

Schecter found that, in the analyses of these women, often the rapprochement crisis of the separation-individuation phase is recapitulated as the taboo success is approached. Mahler (1966, p. 162) describes some of the developmental issues within the rapprochement sub-phase:

> . . . the collapse of the child's belief in his (sic) own omnipotence with his uncertainty about the emotional availability of the parents, creates the so-called "hostile dependency" upon and ambivalence towards the parents . . . and fear of loss of the object's love, fear of loss, of the object, and fear of bodily injury, mutilation or castration. (p. 243)

In short, the child wishes to exchange places with the mother, to render her impotent, to emerge as the undisputed victor in a battle where the child originally felt defeated. The guilt associated with success frequently has its origins in the unconscious fantasy that the child has achieved success at the expense of the mother, that is, by robbing the mother of her power. The fear is also that, without her power, the mother cannot survive.

Miller (1980) studied patterns of perceived parental responses to success or autonomy-striving by sons and daughters to determine the relationships between these patterns and the presence or absence of fear of success. She found no correlation between perceived parental responses and fear of success for men, whereas there was a significant correlation for the female subjects between fear of success and projected responses of both fathers and mothers. Notable for females was the high correlation between projected maternal response and fear of success.

Two very different hypotheses are offered regarding the etiology of the same observed phenomenon. Freud's dynamic psychosexual-developmental hypothesis attributed fear of success to "forces of conscious . . . closely connected with the Oedipus complex." (p. 214) In contrast, Horner postulates that fear of success is more prevalent

in females because it arises out of cultural mores which identify success-seeking as an unfeminine goal.

Cohen (1974) and Pappo (1972) derived conceptualizations from a psychodynamic rather than a social-learning model. Based upon Sullivanian theory, Pappo theorized that fear of success was an end result of parent-child relationships in which the child's achievement was experienced as threatening to the parent, thereby enveloping such achievement in anxiety and leading to success-avoidance and the development of security operations as protections against the anxiety. Cohen hypothesized that the parental anxiety arose more pervasively in response to the child's growth and autonomy in general rather than being limited to achievement.

Miller's (1980) study focuses on two key issues related to this conflict: the perceived nature of parent's responses to the child's movement toward autonomy and success, and the relationship of those responses to the presence or absence of fear of success. The most striking findings of her study were the differences in the way men and women perceived parental attitudes towards children's success, and the difference between the sexes in relation to those perceived or projected attitudes and fear of success. More specifically, the mother-daughter pairs were unique. The mothers of daughters were perceived, on the average, as indifferent rather than disapproving.

Miller (1980) reflects that, in our culture, competition, aggression, and success are relatively proscribed for women and even more strongly prescribed for men. Culturally enhanced competitive strivings conflict with the expectation of retaliation and loss of love. Loss of love is certainly anxiety-producing, and may be equated with parental anxiety communicated through emotionally laden approval and disapproval. As hypothesized in Sullivanian theory, if the mother, who is the primary caretaker, is idiosyncratically threatened by these moves towards success and autonomy, she communicates that anxiety to the child. The threat may be greater for mother-daughter than for any others because of the cultural definition of feminine development. At the Oedipal phase, therefore, not only is resolution theoretically more difficult for girls than boys (Freud, 1931, 1933), but the girl comes to it already more burdened by the effects of maternal anxiety and of cultural sex-role norms.

Ours is a competitive, success-oriented culture in which males are socialized early and generally given few options. Thus, assertion and autonomy in small boys are encouraged, if not demanded, and not only does the boy retain his primary object in the Oedipal struggle, but he also has greater freedom and necessity to identify with the father, who in turn, has an investment in his son's ultimate success. Miller's study indicates a uniquely strong and troublesome

attribution of daughters to mothers, a finding consonant with Freud's formulations.

In referring to Horner's landmark studies on fear of success, Person (1982) refers to Tresemer (1976) and others who suggest that the crucial conflict in women is between achievement, on the one hand, and fear of loss of femininity on the other. Rather than fear retaliation for aggressive behavior, fear of success is, thus, fear of deviance. Bardwick (1979) saw women's fear of success as ultimately the fear of never being close and loved by a man. Women's success anxiety is not a fear of assertion and competition per se, but rather a fear of being labelled deviant from the feminine norm and consequently rejected.

Fear of deviance can result in urges toward conformity. Ticho (1976) gives examples of brilliant women who keep grades down so as not to arouse disapproval of male students. Threats of social ostracism, particularly by men, are especially potent when we consider that women are socialized so that success is primarily defined by their desirability to males and ultimately to marriage. These external expectations are internalized in the ego-ideal. It is fear of the consequence of deviance that leads to avoidance of success. Thus, fear of success, unlike work inhibitions, is a result of specific individual neurotic conflict, manifested by

anxiety responses responding in self-defeating behaviors precluding success.

Freud (1916) first described fear of success as guilt reactions engendered during the Oedipal period. Ovesey (1962) describes success phobia, and suffering from inhibition of assertion, aggression, and competition, as being derived from a childhood wherein forward movement is perceived as rivalrous and permeated with violence. This is the nuclear conflict from which the success phobia is set in motion (Ovesey, 1962).

Applegarth (1977) in regard to other women analysts reports that the conflict in women reflects guilt and fear at surpassing the mother.

The fear of public speaking and public exposure are special problems among successful women. Putting oneself forward among women is just as much sexual as assertive, since female competition is traditionally a sexual competition, the point of which is to be noticed by men. Women feel more comfortable speaking publicly when pregnant, or in mid-life, because for some, they feel they have a biological safeguard against sexual exhibitionism. These fears, like stage fright, are most often inhibitions against libidinal or sexual impulses, not aggressive ones. As such, they are structurally equivalent to fear of success,

except that libidinal rather than aggressive impulses are defended against (Applegarth, 1977).

The sense of fraudulence and fear of exposure as a fraud is prevalent in self-evaluations of women at all levels of achievement. While, all too often, this is interpreted in terms of a castration complex, and penis envy, the underlying conflict is related to the fear of deviance, that is, that the requirements of being feminine, as culturally defined, and the requirements of competence are in conflict. The professional, successful woman protects her "femininity" by denying the authenticity of her ambition behind an ingratiating mask: she often practices a real deceit. The sense of fraudulence is displaced from an imposture about intent to a subjective sense of inadequacy.

Readiness to feel fraudulent has roots in women's being taught to please, to ingratiate, to make comfortable, even if it means denying their own feelings. In sexual life, this appears in the widespread practice of faking orgasm, which is based on deference to the male, need for his approval, and shame at presumed sexual inadequacy. Above all, it is motivated by the fear of loss of the male sexual partner.

In psychoanalysis, the major underlying dynamic in women is not penis envy, but loss of love. This was first alluded to by Freud (1924). Part of the female patterning

undoubtedly comes from gender socialization and the prescriptions of the female role.

From the analytic point of view, the question is whether the female tendency to dependency and affiliation is solely an adaptation based on role expectations and external cultural limits to autonomy, or whether it is implicit in object relations of the pre-Oedipal or Oedipal period the causes of the female preoccupation with affiliative ties cannot be proved, but seem related to, or at least reinforced by, the developmental sequence of female object relations.

Differences in the separation-individuation phase of development are stressed by certain authors as part of female patterning. Chodorow (1978) argues that girls have a more difficult time separating from mother because mother regards her daughter as a narcissistic extension of herself. In Chodorow's scheme, girls ultimately turn to their fathers, and, subsequently to other men, in order to escape mother. Greenson (1956) and Stoller (1966, 1968, 1976) claim that separation-individuation is more difficult for males as they must disidentify from their mothers.

Ovesey and Person (1962, 1980) argue that separation-individuation is equally difficult in each gender, and each makes different reparative moves when separation anxiety disrupts normal separation-individuation. Females fear loss of love related to fear of abandonment by the mother as one

aspect of this fear. Fear of loss of maternal love is often reactivated in adolescence in the face of actual maternal disapproval of the daughter's sexuality, autonomy, or selection of a different role model. It is this early libidinal loss, the girl's renunciation of mother and turning to the father in the Oedipal period, along with the threat of loss of the dependency object, that lies at the center of the pervasive dread of loss of love (Person, 1980).

Ovesey and Person's formulation contrasts with the classical view that the girl is less fearful than the boy during the Oedipal period because she has already been castrated, i.e., she has nothing to lose (Freud, 1925). On the contrary, they argue, she is more intimidated because her very rival is also the source of her dependency gratification. They emphasize the effects of the female monopoly of child care, with its attendant asymmetry during the Oedipal situation, rather than the sexual difference. This view is consonant with Freud's discovery of the importance of the girl's pre-Oedipal tie to her mother (Freud, 1931, 1933).

> It is the girl's ambivalence toward her mother, not penis envy, which is the central dynamic in female sexual inhibition. The all-pervasive dread of loss of love and work inhibitions are all tied together. (p. 120)

Symonds (1976) feels that women therapists are being sought out increasingly by women, and this is a measure of their increased self-esteem as women. Women feel they would be better understood by a woman therapist because women therapists have gone through some of the same struggles. Women have been pressured from early childhood into dependent, submissive roles, and by and large, have accepted them. This has become a cultural stereotype for what is considered a normal feminine personality, since, at the core of this personality pattern, females in our culture are expected to be dependent.

Horney (1950) describes the dependent character type, and the complex web of conflicting feelings and needs which each neurotic character-type experiences. The dependent individual is caught between her compulsive efforts to be compliant, lovable, and self-effacing, and her healthy needs for growth and self-expression. Horney describes conflicts and symptoms which she calls "neurotic dependency" which have been idealized by our culture as "femininity."

Deutsch (1944), a classical psychoanalyst, describes the "healthy woman" as:

> The ideal life-companion, they are ideal collaborators who inspire their men and are themselves happiest in this role . . . the loveliest and most unaggressive of helpmates . . . they want to remain in that role; they do not insist on their own rights, quite the contrary. They are easy to handle in every way if one only loves them.

> If gifted in any direction they preserve the capacity for being original and productive, but without entering into any competitive struggles. They are always willing to renounce their achievements, without feeling that they are sacrificing anything, and they rejoice in the achievements of their companions, which they often inspired. They have an extraordinary need of support when engaged in any activity directed outward. (pp. 290-291)

Young girls are given these values and expectations by parents, teachers, and society, in short, by the entire culture. In order to achieve this ideal, a woman must work at it. To be able to renounce one's own achievements, without feeling that one is sacrificing, requires constant effort. To be lovely and unaggressive, a woman spends a lifetime keeping hostile or resentful impulses down. Even healthy self-assertion is often sacrificed since it may be mistaken for hostility. Therefore, women often repress their initiative, give up their aspirations, and, unfortunately, end up excessively dependent with a deep sense of insecurity and uncertainty about their own abilities and self-worth.

The differing attitudes toward aggression in men and women are reflected in work. In treatment, women often complain of themselves that they are aggressive and competitive, with the clear feeling that these are entirely bad traits, and not consistent with the ideal they have of themselves. When they are competitive with men, their fears are

reinforced from society especially when they are labelled castrating.

A related superego attitude of importance is the attitude toward curiosity, exploration, and especially towards internal self-regulation. All of these tend to be held up as admirable for men, but usually not for women, who have been systematically taught that it is desirable to please others and conform to the expectations of others. Curiosity and exploration, besides being superego matters, also carry with them elements of danger. One is apt to get into trouble by wandering onto unknown paths. Men and women are encouraged toward different ideals with respect to danger. Narcissism demands in men that they attempt to suppress fear, while women are to allow themselves fear without shame. Women often feel, consciously, that they must emphasize their weakness in order to build up the self-esteem of a man. They fall into the group of those who suffer guilt over their strength and capability.

Bardwick (1971) reflects that girls are generally more dependent, more conformist, more compliant and more vulnerable to interpersonal rejection than boys. She thinks that the atypical independent girl who has a high internalized need to achieve, and the dependent feminine girl who has fused achievement and affiliation rewards, represent the maturation of the two different personality models that are

available in this culture, albeit unequally. For boys, only the independent personality model is sanctioned.

Bardwick stated: "Perhaps I am beginning to see a new feminine pattern emerging in which interpersonal success and traditional behaviors remain important, while the achievement success becomes equally important." (p. 187)

## Countertransference

The author defines countertransference as the bringing into play, especially but not exclusively in the therapeutic session, any portion of the totality of the therapist's attributes, experiences, attitudes, through the stimulus of the resonating relationship with the patient. The therapist may reveal her reaction by her speech or demeanor, or by a nuance of facial expression or tone of voice.

Countertransference refers to the feelings, attitudes and opinions of the total person, and reflects her stage of life, her age, the givens of her life experiences, how she performs the multiple roles she plays, any acute crises or events in her life, and all of the separations and losses that comprise her dynamics, conscious and unconscious. The therapists countertransference, then, is that which she feels toward the patient and within herself, and is a product of the therapist as a total person.

In this study, countertransference refers to the consciously felt and reported inner experiences or feelings of the female psychotherapist in her case reflections about her woman patient. It is also defined so as to take into account the deeper, more hidden "blind spots" or unconscious which are a part of the countertransference. These "blind spots" are alluded to by inference of the author.

Kernberg (1965) describes two contrasting approaches in regard to the concept of countertransference. In the first approach, the "classical" one, countertransference is defined as the unconscious reactions of the psychoanalyst to the patient's transference and remains close to the use of the term as proposed by Freud and to his recommendation that the analyst overcome his countertransference (p. 38). This approach also tends to view neurotic conflicts of the analyst as the main origin of the countertransference.

The second approach is called the "totalistic" one, wherein countertransference is viewed as the total emotional reaction of the psychoanalyst to the patient in the treatment situation. This school of thought believes that the analyst's conscious and unconscious reactions to the patient in the treatment situation are reactions to the patient's reality as well as to his or her transference, and also to the analyst's own reality needs as well as to his or neurotic needs. This second approach implies that although

countertransference should certainly be resolved, it is useful in gaining more understanding of the patient (Kernberg, 1965).

Reich (1951), Glover (1955), Fliess (1953), and, to some extent, Gitelson (1952) are the main exponents of the "classical approach." Among the main exponents of the "totalistic" approach are Cohen (1952), Fromm-Reichmann (1952), Heimann (1950), Racker (1950), Weigert (1952), and Winnicott (1949, 1958). The totalistic orientations' main criticisms of the "classical approach" are that it is a restricted definition of countertransference which tends to obscure its importance by the implication that countertransference is something basically "wrong," this leading to a "phobic" attitude of the analyst toward his or her emotional reactions and a limiting of his other understanding of the analytic situation.

Winnicott (1949) states: "When the analyst feels that his (sic) emotional reactions are important technical instruments for understanding and helping the patient, the analyst feels freer to face his positive and negative emotions evoked in the transference situations, has less need to block these reactions, and can utilize them for his analytic work." Further, he points out that there exists an "objective countertransference," i.e., natural reactions of the analyst to rather extreme manifestations of the patient's behavior toward him or her.

The focus of the present study presumes a totalistic approach to countertransference. A "totalistic" concept of countertransference does justice to the conception of the analytic situation as an interaction process in which past and present of both participants, fuse into a unique emotional position involving both of them. Sullivan (1953) makes this concept of interpersonal interaction process a cornerstone of his theories.

Reich (1951) separates "permanent countertransference" reactions from "acute countertransference" reactions, the former due to character disorder of the analyst, and the latter as determined by the different transference manifestations of the patient. She feels that permanent countertransference would require more analysis of the analyst. Through the mechanism of empathic regression in the analyst, conflicts of the patient's past reactivate similar conflicts of the analyst's or therapist's past; this regression may also reactivate previously abandoned, old character defenses of the analyst.

Racker (1957) further develops the idea that countertransference reactions of the analyst can be used to obtain information about the inner emotional constellation of the patient, classifying the identifications that take place in the countertransference reactions into two types: "concordant identification" and "complementary identification."

"'Concordant identification,'" according to Racker, "is an identification of the analyst with a corresponding part of the patient's psychic apparatus: ego with ego, superego with superego. Under the influence of concordant identification, the analyst experiences in himself the central emotion that the patient is experiencing at the same time." And, Racker states, "one might consider empathy as a direct expression of concordant identification." (p. 49)

"Complementary identification" (a concept first described by Helene Deutsch) refers to the identification of the analyst with the transference objects of the patient. In that position, the analyst experiences the emotion that the patient is putting into his transference object, while the patient is experiencing the emotion which he or she had experienced in the past in interaction with that particular image.

Money-Kyrle (1954) says that concern for the patient's welfare stems from the combination of reparative drives in the analyst counteracting his or her early destructive tendencies, and from his or her parental identifications.

Winnicott (1949) suggests that concern stems from modulated and restricted guilt feelings. He suggests that the child's successful working through of repeated cycles of aggression, guilt, and reparation makes this development possible. He says,

> In concrete terms, concern implies ongoing self-criticism by the analyst, unwillingness to accept impossible situations in a passive way, and continuous search for new ways of handling a prolonged crisis. It implies active involvement of the therapist as opposed to narcissistic withdrawal and realization of the ongoing need of consultation with and help from one's colleagues.
>
> Willingness to review a certain case with a consultant or colleague, as contrasted with secrecy about one's work is a good indication of concern. (p. 202)

Epstein and Feiner (1979) reflect on key issues and themes in countertransference from their inception to their current status in psychoanalytic thinking.

Since Freud (1910) stated:

> We have become aware of the "countertransference" which arises in (the physician) as a result of the patient's influence on his unconscious feelings . . . he shall begin his activity with a self-analysis and continually carry it deeper while he is making his observations on his patients. (p. 278)

And when Freud (1912) further said:

> The analyst must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient . . . (so) the doctor's unconscious mind is able . . . the reconstruct (the patient's unconscious) . . . (p. 247)

these two thematic constructs, countertransference as a hindrance, and the therapist's use of his or her own unconscious to understand the patient, have intertwined throughout the historical development of psychoanalytic concepts of countertransference.

Racker (1953) in Argentina; Winnicott (1949), Heimann (1950), and Little (1951) in England; in the United States Fromm-Reichmann (1950), Mable Black Cohen (1952), Thompson, Crawley and Tauber (1952), and Tauber (1954) are analysts who made significant contributions by turning to data of the countertransference to seek a better understanding of the patient in the ongoing process of psychoanalysis.

It was Heimann (1950), Little (1951, 1957), Winnicott (1949), and Racker (1953) who actually broke through the barrier of the prevailing classical view that countertransference was simply a hindrance to effective psychoanalytic work. Their ideas concerning the therapeutic usefulness of countertransference data have foreshadowed all subsequent developments. In fact, 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.

Heimann (1959) offered several revisions of the classical concept. First, she extended the term to include all of the feelings which the therapist experiences toward his or her patient and no longer restricting it, as did Freud, to the pathological components of the therapist's own response:

> The aim of the analyst's own analysis . . . is not to turn him (sic) 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 up 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. (p. 491)

Heimann considered

> The analyst's emotional response to his patient within the analytic situation . . . one of the most important tools for his work. The analyst's countertransference is an instrument of research into the patient's unconscious. It should not be communicated to the patient, but it should be used as a source of insight into the patient's conflicts and defenses. (p. 493)

This remains the widespread view among analysts of almost all the schools. (Langs, 1976; Sandler, 1976, 1979).

Winnicott (1949) dealt with several issues. He distinguished the idiosyncratic from the therapeutically useful countertransference. Winnicott, in this essay, went far beyond the traditional view of countertransference as a hindrance and taboo, making an excellent case for its usefulness not only as a source of information about the patient, but about the ongoing analysts as well. He emphasized that the analyst's intense countertransference feelings, when "objectively" evoked by the patient may be needed as feedback, and that this need for feedback is nothing less than a maturational need.

Racker (1953, 1958) more completely than any other writer in the psychoanalytic literature addresses himself to a full study of the issues of countertransference. He attempted to penetrate the countertransference experience to its depths, illuminating its meanings in detailed patient-therapist transactions, and formulating interpretations based on his understanding. He delineated the normal predispositions shared by analysts, any of whom under certain conditions, can find themselves in the emotional position of the child vis-a-vis the patient-parent. Racker termed this complex of predispositions and its manifestations "the countertransference neurosis," implying that it was as natural and normal a development in the analyst in response to his or her patient as is the transference neurosis in the patient. Feiner (1979) and Issacharoff (1979) have expanded on this theme.

Racker's notion of countertransference neurosis is that it is inevitable and, once understood and accepted as such, yields easily to self-analysis. The totality of the therapist's countertransference, even though it may be dominated by idiosyncratic or even pathological components, is likely to yield significant information about the patient's immediate ego state.

During the past few years, interest in countertransference as a valuable component in psychoanalysis and

psychoanalytic psychotherapy has risen with increasing spirit and totality among the various psychoanalytic schools. Definitions, however, vary with at least three conceptions currently in use: (1) the totalistic conception, in which all feelings and attitudes of the therapist toward the patient are considered countertransference; (2) the classical conception, in which countertransference is viewed as unconscious, resistive, reaction of the analyst to the transference of the patient, or parts of the patient, and as containing both neurotic and non-neurotic elements; and, (3) the view of countertransference as the natural, role-responsive, necessary complement or counterpart to the transference of the patient, or to his or her style of relatedness.

Racker (1953) provides some insight here:

> The lack of scientific investigation of countertransference must be due to rejection by analysts of their own countertransference--a rejection that represents unresolved struggles with their own primitive anxiety and guilt. These struggles are closely connected with those infantile ideals that survive because of deficiencies in the personal analysis of just those transference problems that later affect the analyst's countertransference. (p. 315)

The first distortion of truth in the "myth of the analytic situation" is that analysis is an interaction between two personalities, in both of which the ego is under pressure from the id, the superego, and the external

world; each personality has its internal and external dependencies, anxieties, and pathological defenses; each is also a child with his or her internal parents, and each of these whole personalities--that of the analysand and that of the analyst--responds to every event of the analytic situation. Besides these similarities between the personalities of analyst and analysand, there also exist differences, and one of these is in "objectivity." The analyst's objectivity consists mainly in a certain attitude toward his or her own subjectivity and counter-transference (Racker, 1968).

True objectivity is based upon a form of internal division that enables the analyst to make him- or herself (his or her own countertransference and subjectivity) the object of continuous observation and analysis (Racker, 1968). As early as the late 30s and early 40s, Harry Stack Sullivan (1953) and Erich Fromm (1947), stressed the limits and fallability of the analyst in participation with the patient.

Sullivan (1953), together with Fromm-Reichmann (1950), "humanized" the therapist. That is, they pointed to the significance of the analyst as a real object. They rejected the orthodox "mirror" concept as the analyst's only function, not just because they believed that the opacity of the mirror-analyst and the separation of the patient's affectivity

from the analyst's were impossible to maintain in light of the recognition of a field of forces in the consulting room. The idea was also advanced that awareness and confrontation of the myth of the analyst's anonymity actually furthered the work (Cohen, 1952; Fromm-Reichmann, 1950).

Accordingly, Fromm (1947), for whom the analyst was a "rational authority," rejected the idea that anyone, simply by virtue of being an analyst and having undergone a training analysis, is, therefore, a possessor of superior mental health. Fromm believed that psychoanalysts must face endlessly in themselves the same regressive forces others are heir to, and he, therefore, advised that analysts engage in lifelong self-analysis. This was the same advice that Freud offered in 1910 (and later in 1937), but Fromm went beyond the need to gain mastery over "complexes," or the "abrasiveness" of the depressed. He was concerned lest those forces insidiously erode an analyst's potential for growing and living fully.

Countertransference is now seen as a normal, natural interpersonal event, rather than an idiosyncratic, pathological phenomenon. This has contributed to a heightening of psychoanalytic consciousness, facilitating the shift from viewing countertransference reactions solely as a hindrance, to the possibility of grasping the data of countertransference for their potential value in understanding the

patient, and the therapeutic relationship, and in formulating interventions which deepen and intensify the psychoanalytic process.

There has been an increasing convergence and integration of the intrapsychic and interpersonal field orientations, points of view which were, some years back, evidently polarized. Freud alluded to such an integration in 1912, but only today are the internal processes of patients and analysts being examined for the impact each has on the other.

Wolf (1979) sees a shift in emphasis away from the perception of countertransference as an undesirable interference in the analytic process emanating from the psychoanalyst. Increasingly attention has been called to the uses of countertransference as a diagnostic and therapeutic tool in the conduct of psychoanalytic treatment.

Two considerations that the author feels are essential to any discussion of countertransference have to do with the presence of envy. First, like countertransference, one must accept that like countertransference itself, an envy is often present. Second, one must realize that envy, like countertransference, is not negative, but rather necessitates a concern. The greatest protection against acting out one's envy, is an awareness, acceptance, and understanding of it in ourselves, as therapists. Allphin

(1982) says that clinical social workers, too, often find themselves envying those with whom they work.

Allphin (1981) reflects,

> When people envy those above them in social hierarchy, they may, in order to compensate, subtly encourage the envy of those beneath them in the hierarchy, so the clients of clinical social workers may have their own envy fanned and intensified, rather than understood and put in an appropriate perspective. (p. 151)

According to Melanie Klein (1924), envy affects the earliest relations of all, that of the infant to the mother. It is an oral-sadistic expression of destructive impulses operative from the beginning of life and having a constitutional basis. In Klein's view, the breast is the prototype of maternal goodness, the first object to be envied. A woman who fears her mother's envy of her creative achievements may be unable to accept support from her mother during her own pregnancy and childbirth.

Allphin (1981), reflecting on envy in the transference and countertransference, says, "A patient who depends on the therapist will envy the therapist for having what the patient needs; when the patient cannot tolerate such envy, and avoids it by refusing to depend on the therapist, therapy is blocked."

Alternatively, a patient who fears the envy of the therapist may fail to improve. Since the transference

replicates the parent-child relationship, the child fears surpassing the parent for fear of the parent's envy, and the patient replicates this experience with the therapist. Helping the patient to become aware of this fear will also help the therapist's progress. (p. 159)

Envy in the countertransference can hinder the therapy's progress in the same way as envy in the transference. It occurs when the therapist envies the patient directly or as a result of introjecting the patient's projection of envious feelings onto the therapist. Consequently, when the therapist feels envy toward the patient, it is always important to discern whether the envy is one's own or the patient's.

Searles (1979) discusses the importance of the therapist being able to experience feelings that may emerge in the patient. An affirming attitude is appropriate in the therapeutic relationship. The therapist needs to be empathic with the patient's envious feelings; rejecting them only makes them stronger.

No matter how much the therapist loves the patient, the therapist cannot avoid at some time, envying the patient. In fact, the patient needs to experience the envy of the therapist at certain times in order to be able to experience his or her own envy.

Envy is a universal effect that can hinder the progress of therapy if it is not recognized in the transference and

especially in the countertransference. Awareness of the manifestations and consequences of envy can help the therapist as well as in the patient. The therapist will then be prepared to make appropriate interventions which, by indicating an acceptance of envy, will help the patient to accept his or her own envy. Knowing about envy in the countertransference will help the therapist to prevent envy from being the motive behind what is done with the patient (Allphin, 1981, p. 153).

# CHAPTER IV

## THEORETICAL FRAMEWORK

The literature reveals numerous points of view, and theoretical inconsistencies in the studies of and approaches relating to female development (several of which were elaborated upon in the Literature Review). Many of the studies dealing with women's issues are unique and vital to our understanding of the intricacies and complexities of the field of women's development. There is no unified theory, however, of female psychosocial or psychosexual development. Vital contributions of certain psychoanalytic viewpoints to the study of female psychology will be used.

Selective aspects of three psychoanalytic conceptual and theoretical frameworks will be used, which the author believes are intimately related to any discussion of women's conflicts. They are: Oedipal themes [Freud's theories of female sexuality (1925, 1927, 1931, 1933); challenges and modifications to Freud's theories as reflected in the works of Schafer (1968, 1974, 1977), Horney (1924, 1926, 1933, 1935), Galenson & Roiphe (1975, 1977), and Stoller (1963, 1965, 1968, 1972)]. These

will be considered within the overall framework of Mahler's (1963, 1964, 1968, 1977, 1981) contributions to development, in particular, her writings and elaborations on the developmental issues inherent in the rapprochement crisis of the separation-individuation phase.

Significant contributions to female psychology, namely, the studies of Horner (1968, 1978) and Hoffman (1965, 1971, 1974), Resemer (1968), and Broverman (1968) were expanded upon in the Literature Review.

For issues of countertransference, selected aspects of the works of Kernberg (1965), Racker (1953, 1968, 1981), and Searles (1965, 1978, 1979, 1981) will be used.

The issues which confront women therapists reflect their varying ambiguities, fears, and conflicts related to being women in our society. The contrasting, ambiguous, and disunified theories of women's psychosexual development reflect that confusion. Freud deserves credit for opening the doors to ongoing psychoanalytic attempts to discover the origins and early identities of women. He acknowledged that his insights into women's development were "unsatisfactory, incomplete and vague" (Freud, 1924) and his question, "What does a woman want?," opened a pathway for many significant contributions to the understanding of infantile sexuality and femininity.

Freud (1924-1933) saw masculinity as the primary natural state from which the girl retreated into femininity upon discovery that she had no penis. He declared that penis envy was a phenomenon directly observable in little girls and believed that girls responded to the discovery of sexual distinction with the assumption that they had been castrated, accepting the nature of clitoral inferiority for the rest of their lives. His general stance was that the path to the development of femininity does not lie open to the girl until she passes through the phallic phase. He stated that the young girl is ignorant of her vagina until puberty. He maintained that masochism was truly feminine. For Freud the missing link was gender identity.

Horney (1924-1933) and Jones (1927-1935) were the strongest critics of Freud's theory, proposing, instead, that rather than femininity representing thwarted masculinity, both femininity and masculinity had predated the phallic phase and had pre-Oedipal origins.

Freud believed that a girl's reaction to the discovery of sexual distinction was decisive not only for female sexual development, but for the personality traits he associated with femaleness: passivity, masochism, and narcissism.

> The little girl, once she recognized she could never be masculine, retreated into femininity as an expression of her inherent inferiority . . . femininity derived from the psychological ramifications of a single, momentous and traumatic perception; the girl's discovery of her anatomic difference from boys, a difference viewed as inadequacy. (p. 208)

The essence of the argument between Horney and Freud was how penis envy should be regarded. Horney felt that the girl turned to her father, not in search of the penis her mother denied her, but rather as a heterosexual object choice out of her innate femininity. Horney felt the girl's choice was grounded in female biology and awareness of the vagina, not from disappointment at the lack of a penis.

Stoller (1964) shared the view of Horney and Jones that gender consciousness was integral. However, he did not view masculinity and femininity as parallel constructs. In his gender theory, gender identification precedes the child's discovery of the sexual distinction. Stoller looked for the roots of gender in the period of infancy. He saw primary femininity (which he calls protofemininity) in the earliest phase of life and saw it as an integral part of emerging identity in both sexes. Greenson (1958) suggested that this raises a special problem for boys, because they must disidentify to achieve an appropriate masculine identity.

Ovesey and Person's (1983) formulation differs from Stoller, who suggests that separation-individuation is, per se, more difficult for males who begin with a female identification and who must disidentify. They state:

> We do not believe that separation-individuation is intrinsically more difficult for males, as Stoller suggests, but, when conflicts arise in separation-individuation, they are adaptively resolved in a way that has different consequences for both sexes. (p. 212)

Schafer (1958-1975) believes that Freud drew erroneous conclusions regarding female morality and the part played by the girl's mother in her development. He posits that the active, nurturant mother has her own sources of pride and consolation. He further states, with regard to Freud's theory regarding female morality, that Freud did not sharply distinguish between superego and moral code. Schafer says:

> It follows that Freud may have drawn exactly the wrong conclusion from his theory. If on account of her different constellation of castration concerns a girl does not develop the implacable superego that a boy does, at least in this respect she might be better suited than a boy to develop a moral code that is enlightened, realistic, and consistently committed to some conventional form of civilized interaction among people. (p. 158)

Gilligan (1980) also posits that women speak in a different voice, the voice of a responsible, caring morality.

The findings of this study clearly foreshadow female therapists' continual reworking of the relationship with their mothers related to separation and identification themes, and their ongoing relationship with their mothers. As Schafer says in his answer to Freud,

> Any psychological approach to the pre-phallic period must center on the girl's primary, intense and ultimately indestructible relationship with her mother . . . one must see the girls and woman as being in a profoundly influential, continuously intense and active relationship not only with her real mother but with the ideal and imagined presence of her mother and with her identification with this mother. (p. 183)

The author views the developmental stage of separation-individuation and, particularly within it, the crisis of rapprochement, as having enormous implications for the developing female child. Later in life, the comfort with assertiveness, curiosity, exploration, and creativity in the young female can be traced to, and derives from, the messages, conscious or unconscious, which are transmitted by her mother. While male parents have increased their participation in child-rearing, for the most part, child-rearing in infancy and childhood is still the major domain of the mother. The degree of her comfort with independence and autonomy will be the degree to which her child fearlessly explores her environment and has a freedom from fear in making choices. However, as mothers, women

are a product of the culture. The anxieties that many women feel about independent, autonomous behavior is transmitted from mother to child, and from generation to generation.

Chodorow (1978) did an analysis of contemporary child-rearing practices which emphasizes the importance of emotional, relational bonding in young women while abstract, work-oriented ties to the social world are valued in the rearing of male children.

Horner (1965, 1971) conceptualized the motive of women to avoid success as coming out of anxiety that success will be followed by negative consequences. She says:

> The aggressive, and by implication, masculine qualities inherent in a capacity for mastering intellectual problems, decision making and achievement, are considered fundamentally antagonistic to or incompatible with femininity. (p. 156)

Hoffman (1974) continued the exploration of fear of success by concluding that women feared success because they feared affiliative loss. Both acknowledged that the psychodynamic causes of this phenomenon were among the yet-to-be-answered questions.

Perhaps some of the answers were found in two longitudinal psychoanalytic observational studies that are deemed of special significance for this study: Mahler's (1963, 1964) parallel studies of psychotic and normal

children beginning with their earliest development, and the studies of Galenson and Roiphe (1968, 1975).

Kramer (1978) analyzes the significance and implications of Mahler's separation-individuation theory:

> Mahler's symbiosis-separation-individuation theory is much more than an object relations theory. Her theory adds to that of the ego in its functions, and to the theory of drives . . . and describes the complex and vital structuring, in much detail, of object and self from the undifferentiated child-mother symbiosis to the attainment of object- and self-constancy. (p. 242)

Mahler (1981) reflects upon aggression in the service of separation-individuation and says that the difficulties of resolving mother-daughter conflicts in the pre-Oedipal, Oedipal, and post-Oedipal realm are evident. She points to the difficulties for women, in particular, in achieving separation-individuation and differentiation from the mother.

Friedman (1980) points to new discoveries yet to be made in the mother-daughter relationship, and believes there is something in the separation and identification process that makes the daughter's struggle for independence and a sense of herself as a woman unusually difficult to achieve.

The author views both from the vantage point of her clinical practice with women patients, and from the findings within this study, believes that it is

within the transference relationship that unresolved or faulty separation-individuation conflicts can be reworked for female patients, and, as the study emphasized, for female therapists as well.

Galenson (1977) studied female graduate students and wrote on the phenomenon of "examination anxiety" in women. She explored women's fear of competition, a fear recognized as more common for women than for men. Impending exams led these women to fear object loss, feel guilt and self-reproach, and to feel anxieties about intellectual perfection. Under this pressure, they showed the pull of regressive wishes for an earlier dependent relationship as a way out of the competitive showdown. Galenson believed that this anxiety in women differs from the same symptoms in men, and that this difference stems from divergent lines of development in the two sexes, beginning in the latter part of the second year of life.

Galenson and Roiphe (1968), in their longitudinal studies on infants and toddlers, found data that lent support to Freud's (1933) statement that the little girl's discovery that she was castrated became a turning point in her growth. They believed, however, that this discovery came much earlier than Freud indicated. They also believed that the subsequent sense of loss the little girl felt may be profound to moderate, depending on such

factors as the quality of the tie to the mother, earlier bodily experiences, the availability of the father at this time, and the mother's conscious and unconscious attitudes.

According to their findings, Galenson and Roiphe believe that these castration responses to the sexual differences are important organizing influences from this time onward, and determine the direction of the psychosexual development of the girl, as well as aspects of her personality, both in an enhancing and inhibitive way.

The relevance of Galenson and Roiphe's work for the current study is that many of the women patients, and several of the women therapists, reported inhibitions and prohibition of actualizing efforts. Galenson and Roiphe tie this to the following phenomena:

> Early recognition of sexual differences take place during the era when intellectual functioning has begun to assume some characteristics of secondary process thought. Presymbolic forms, such as gesture and semisymbolic play are developing during the second year of life and speech is just emerging. The new symbolic function is utilized in the child's expanding knowledge of the world, and is also utilized for the expression of thoughts and affects. (p. 411)

What is crucial to the feelings about intellectual and creative pursuits is reflected in this statement by Galenson (1977):

> It would appear . . . that the budding intellectual function is involved, in many little girls, with concern over genital intactness, . . . older renewed anxieties of object and anal loss. It is not surprising to find, then, that the intellectual function is perceived by many, if not all, women as phallic. (p. 94)

Object loss, or in common parlance, the loss of the significant other, is a source of concern to women who excel, who succeed, or who actualize intellectual or creative efforts. As Mahler's and Galenson and Roiphe's studies show, certain of the origins of this conflict about female separation and autonomy and female achievement has its roots in the earliest separation-individuation experience.

The ability of the therapists in this study to be aware of their countertransference in relation to their women patients reactivated for the therapists feelings about their female identity, and resurrected memories of their own separation experiences, in many cases, resulting in a revisiting and reworking of feelings about the relationship to their mothers.

In contributions relevant to this study on countertransference, Searles (1979) speaks of the need for therapists to be open and honest about their countertransference. As he says:

> It is dangerous not to be honest, it is not dangerous to have the countertransference

> issues, and not dangerous to have the feelings, it is dangerous not to be in touch with them. (p.65)

Kernberg (1965) describes two contrasting approaches in regard to countertransference, the "classical" and the "totalistic." The former stays close to the use of the term proposed by Freud, two of the proponents of which are Reich (1951) and Glover (1955). The latter is viewed as the total emotional reaction of the psychoanalyst to the patient in the treatment situation.

Racker (1953, 1958) attempted to penetrate the countertransference experience to its depths, illuminating its meanings in detailed patient-therapist transactions. He viewed it as a normal predisposition shared by analysts, any of whom, under certain conditions, can find themselves in the emotional position of the child vis-a-vis the patient-parent. Racker termed this complex manifestation "the countertransference neurosis," implying that it is a normal development in the analyst in response to his or her patient.

Heimann (1950), Winnicott (1949), and Racker (1953) broke through the barrier of the prevailing classical view that countertransference hindered effective psychoanalytic work. Winnicott and Racker went beyond the traditional view of countertransference, making an excellent case for its usefulness not only as a source of

information about the patient, but about the ongoing analysis as well.

Wolf (1979), reflecting upon Kohut's contribution to viewing countertransference, said, "Typically, what at first appears to be an obstacle in the path of psychoanalysis is transformed into one of the tools that facilitates the psychoanalytic process." (p. 445)

Finally, the study reflects, and Searles (1968) and Searles and Langs (1981) support, the view of the opportunity for the therapist to grow through insights gained by attentiveness to their countertransference.

# CHAPTER V

# FINDINGS

## Overview of Findings

As described in Chapter II, Methodology, countertransference themes were organized, by content analysis, into five major categories.

Theme 1, "The Therapist's Relationship with Her Mother," was a major issue for four of the therapists interviewed (B, C, K, and Q). An aspect of this theme appeared as a secondary issue for six psychotherapists (A, M, O, R, S, and T).

Theme 2, "Fear of Success," was a major issue for six psychotherapists (D, E, F, M, N, and T), while it appeared as a secondary theme for two additional therapists (I and R).

Theme 3, "Role Conflicts," was the major issue for four women (I, L, O, and S). Nine women described it as a secondary issue (A, B, C, E, F, M, N, P, and T).

Theme 4, "Envy in the Countertransference," was the main issue for three therapists (A, H, and R) and it was a secondary issue for two therapists (C and D).

Finally, Theme 5, "Life Stages," appeared as a major issue for three of the women interviewed (G, J, and P) while it was a secondary issue for only one (H).

Clear-cut distinctions between themes were extremely difficult to make, and each woman psychotherapist emphasized more than one issue. Division of the countertransference material into a series of theme areas was done mainly to help organize and illustrate the major issues in an orderly way. Nevertheless, as interview excerpts presented in this chapter will demonstrate, the issues often overlap and intertwine.

For example, one therapist, R, experienced envy in the countertransference relating to her patient's competition and intellectual excellence. However, Theme 1, "Therapist's Relationship with Her Mother," became very prominent for her as she recalled her mother's early messages to her about aspirations and learning. Traceable to these early messages, she had felt inhibited creativity in herself, as well as an exaggerated aversion to intellectual exhibitionism. These issues had coalesced into a more generalized fear of success. At the time of the interview, this therapist was also going through a mid-life mourning process.

This interweaving of major and lesser issues led the author to devise a subcategory of responses for each

major theme, which represented statements of related issues made by the therapists. Thus, while the five major themes consist of core issues reappearing consistently throughout the interviews, the subcategory issues are the specific components mentioned by one or more psychotherapist which comprise a portion of the major theme.

Theme 1, "The Therapist's Relationship with Her Mother," includes three related issues:

a. Maternal identification;

b. Separation and individuation;

c. Maternal countertransference.

Theme 2, "Fear of Success," was elaborated in five subcategories of therapists' statements:

a. Inhibitions in work;

b. Conflicts regarding ambition, achievement, and assertiveness;

c. Inhibitions in creativity and intellectual pursuits;

d. Subjugated aspirations;

e. Low self-esteem, that is, devaluation of success or accomplishments.

Theme 3, "Role Conflicts," included three subcategories of issues:

a. Familial vs. career aspirations, that is, professional vs. relational pursuits, particularly in terms of the balancing of roles for these professional women;

b. Conflicts over femininity and masculinity;

c. Role modeling.

Theme 4, "Envy in the Countertransference," was two-pronged. The therapist's envy was expressed in feelings and conflicts related to:

a. Dependency and autonomy issues;

b. Mourning.

Theme 5, "Life Stages," refers to cycle of life of the therapist, two subcategories:

a. Mourning;

b. Mid-life.

Mourning must be considered in two ways for the purposes of this study. First, mourning understood to be a component of envy in the countertransference may be thought of as natural, idiosyncratic issues related to the therapist's losses. All therapists mourn. In the countertransference, they are confronted with extremely intense feelings related to their own separations and losses. In contrast, mourning as a component of the Life Stages theme refers to mourning in the context of reevaluation: mourning for what has not come to pass in life, and mourning for what will never be.

Interview findings which pertain to each major theme and its subcomponent areas will be presented in the subsequent sections of this chapter.

## Theme 1:

## The Therapist's Relationship with Her Mother

This theme cuts across the other four themes in a way which underscores the enormously strong relationship between women and their mothers. Material in the interviews reflects the life-long efforts which many women make to separate from their mothers, resolve aspects of their relationships with them, individuate, and find their own identity. Three aspects of the theme are identified from the interviews: identification with mother; separation and individuation; and maternal countertransference. For purposes of presenting the data, a slightly different organization will be used. First, material from the interview with Therapist B will be presented to illustrate the impact of the maternal relationship on the integration of certain aspects of female identity, as illustrated through countertransference themes. Next, the secondary theme of separation and individuation will be explored through the interview with Therapist Q. Finally, material about maternal identification will be presented in connection with interview data from Therapist C. Since virtually every interview contained material illustrating the phenomenon of maternal countertransference between therapists and patients, this secondary theme will be treated across all three cases rather than unto itself.

Finding the Lost Mother

Therapist B's task, in her work with an interesting but resistant female patient, can be described as the repair and reworking of her relationship with her mother via the patient's transference as well as enduring the ambivalence of the therapeutic relationship. B's experience is a good example of the way in which a therapist can experience, unconsciously, a reactivation of carefully buried parts of themselves in connection with working with certain patients. B's patient presented evidence of very early deprivation which put B in touch with significant memories of unresolved feelings of loss about her long deceased mother.

B's patient was extremely repressed, given to lying, and to challenging B with repeated cancellations. B's task as a therapist was to stay with her and encourage her to separate and individuate as she struggled fitfully to break away from a confining past, her enormous fears about herself, and her feelings of inadequacy. In this process, B became the healthy, strong, transference "mother" who took pride in the patient's progress, in contrast to the patient's real mother who, severely depressed and withdrawn, had emotionally abandoned her at an early age.

In discussing her maternal countertransference, B echoed several other female therapists (C, K, L, and T) in saying:

> It's almost like a daughter that I would like to have had. I'm a little amazed by the amount of positive feeling I have for her because I allowed free reign to all her negative acting-out, and now, having analyzed it, I can let my positive feelings emerge. But it's very hard! Both the negative and the positive feelings were so much more than I usually have toward other patients.

The therapists' need to rework conflicts regarding their mothers, and their desire to give to particular female patients what they themselves had been denied, became evident in several of the interviews. Often, a therapist sought to provide for her female patient a therapeutic relationship that was "different" from, and richer than, the relationship either of them had experienced with their mothers. Several therapists sought to compensate for belatedly recognized lacks in their own psychotherapy by providing for their own patients what they had been denied as patients. B said:

> What I realized was that I was not able to ventilate to a mother [woman analyst], perhaps because I needed to protect her or because I was afraid of her fragility. [B became visibly emotional and upset at this point.] In reality, I felt responsible for her, and had to take care of her. I think that's what this person [patient] evoked in me. I was tolerating her to act out all this negative transference and resistance,

> and I accepted it. And nobody had ever accepted it from her before. I allowed her to do what I could not do, but not just what I couldn't do, but what I couldn't allow any girl to do.

A common thread among female therapists appears to be the need to repair aspects of their relationships with their mothers. B said:

> My work with her [the patient] really reworked something for me. Here was the first time in a treatment situation I allowed a woman total aggression and ventilation, and now I've emerged on the far side of it with her.

The author commented that B had helped her patient to discharge the enormous core anxiety about her own destructiveness, thus freeing her to become her own person and live her life differently in the world. B responded:

> Yes, absolutely. Her relationship with her mother was so complex. Her mother was a depressed, withdrawn woman, and she [the patient] won the Oedipal victory. So I did free her, and she helped me to free something in myself that I needed to free.

It was during the interview that B came to the startling realization that her patient actually looked like B's own mother, that both had the same childlike characteristics. Nearly every woman therapist saw some new, previously unrecognized piece of her relationship with her mother as she discussed the patient she had selected to present. In the discussion portion of the interview, the author and virtually every therapist

pondered together whether there was any woman who did not have something to repair with her mother. B noted that every woman must be able to stand apart and look at her mother, but in order to achieve such separateness, one must first become close to the mother. B's work with her patient had enabled her to get close to an aspect of her mother which had been extremely significant to her.

During the work with her patient, B experienced both memories and insights. She recalled:

> Actually, I had more than one mother. I was raised by my grandmother, so that my mother was floating somewhere out there and I had to pull her back into me to see who was my mother. My mother ran away all the time. She was off traveling with my father, and my grandmother stayed home and took care of me. My patient also kept running away from me, so she represented the mother who ran away -- but I also became the mother who stood still for her, and let her run away.

Mahler (1963, 1964, 1968, 1970, 1975, 1981) wrote about the crucial importance of the mother's availability during the rapprochment phase of the infant's separation and individuation. B, like many therapists, gave to her woman patient what her mother had not given her. About her patient, B said, "She had to work through, in the transference, while I held still." When the author commented, "That is, no matter what the degree of testing, you'd still be home for her," B agreed, saying, "Right, even though she had won an Oedipal victory."

Mahler's practicing subphase of separation-individuation is manifested in the perpetual testing, resistance, movements, and regressions which a patient like B's has to experience. She is carefully testing whether the therapist will remain with her, and once assured, can leave, explore, and be on her own.

Separation and Individuation

One of the most profound results of these interviews is found in the consistency with which therapists return to rediscover their mothers, continuing to work on their maternal identification.

Therapist Q's predominant message to her female patient was, "I want you to feel free in being better than me." Q and her patient shared certain deficits and unresolved conflicts with respect to the maternal relationship. Other therapists (B, M, C, and S) reported similar feelings and experiences.

The female therapist often helps her patient by being available in ways that the therapist's own mother was not. Q makes an extraordinarily clear statement of this kind of reactivation, reconstruction and repair:

> Seeing Rita, my patient, evokes the following feeling from me. As far as I'm concerned, it will always be that her development and growth evoke tremendous pleasure and pride for me. The capacity to facilitate another woman's development is very rewarding, probably because

> it wasn't something that happened for me with my mother. I always had a feeling that she loved me, but I didn't think she knew square one about what would promote my development.

There is a particular mutuality existing between the repair of the patient and the repair of the therapist. Q illustrates this by feeling toward her patient: "Be better than me--do not be afraid of going beyond me."

Q reflects women's capacity to get through giving in the following comment:

> I certainly do not know everything that will promote her development, but I know some of the things--one of which is the desire for her to do better than I. The capacity for me to deal with my envy. This is a lady who is beautiful, married to a successful engineer, and has a lot of support systems. I wanted to do for her what was not done for me, and as conscious as I was of it, that is how receptive she was to it. She had had great deficits, traumas and injuries in her life. So while, for the most part it is an analytic setting, we agree together that I'm there for her in a certain kind of way, which is partly transference, and partly real--it is not all transference.

Recalling her own past, Q said that one of her mother's concerns had been, "If you go to college, you're gonna look down on us." By improving herself, Q felt she would, thus, devalue her mother, who did, indeed, feel threatened by Q's achievements. About her patient, Q said, "I've been conscious all along of wanting her to be as successful as she can be, even going beyond me, which I think she can."

Q amended the author's comment that she had become an encouraging, "constant" source for her patient:

> I've become like a good mother--not a constant source, but a stable source. We're both aware of the fact that I'm not constant, in the sense that I have my own life and I do not feel available outside of the hour. So it is not a constant source, but a steady, stable, predictable source. Predictable in kindness, predictable in sensitivity, predictable in encouragement--but not constant.

Q struck a familiar chord from the interviews with B and C, when she said:

> I even think sometimes she is the daughter I never had. I used to wonder how I could be a good mother to a daughter, without having had a good mother myself. It is such a tremendous sense of triumph to finally be able to be that way with another woman--to promote the welfare of another woman. And now, because of certain women patients like this one, I can say I would be a terrific mother to a daughter. In the past, I never could have said that. That comes from my therapeutic work.

Maternal Identification

Excerpts from the interview with Therapist C underscore her healthy encouragement of her patient's separation process, within the maternal transference and countertransference relationship. C demonstrated how the psychotherapeutic relationship for women patients can become a crucial factor in reworking earlier separation-individuation struggles with their mothers. Not only is therapy a healthier and more constructive arena, but it also offers

potential for therapist and patient alike to rework areas of self-identification.

In her interview, C's satisfaction in helping is evident. She discussed her recognition that her young female patients did not have a healthy maternal model with whom to identify. She was aware that she had provided a model for healthier identification processes, and was gratified when she talked about it:

> The young girls that I have had in long-term therapy who went out into the world and became successful were a tremendous source of satisfaction to me. I wouldn't say that my countertransference was positive all the way, but it was quite positive and it may have contributed to the case, maybe not. But certainly, I felt I had a maternal feeling with them, rightly or wrongly. I took pleasure in their accomplishments, and there must have been some maternal feeling in that. My pleasure in their achievements was probably good for them, because the problems that they brought me were problems of individuation from a quite neurotic mother who found it very difficult to let these girls go and achieve according to their potential, which was considerable.

C's patients struggled with their identities as women, an issue related not only to maternal identification, but also to considerable ambivalence toward their mothers. In discussing them, C focused on the patients' search for healthier models with which to identify. Q exemplifies the woman therapist, who plays a crucial role in becoming a stable, consistent source, enabling the

patient to reestablish a feeling of security and enter into the world to "practice."

C recalled several major issues for her three female patients, who went on to become prominent in journalism, law, and medicine:

> What they really suffered from was: how do you identify with a weak mother when you have a strong, supportive father, and you would rather be a woman? As I look back on these three cases, they wanted to feel warmer and closer toward their mothers, but saw that their mothers really did not achieve very much, did a lot of complaining, and counted on them to becoming that kind of a woman too (and yet the mothers had some jealousy of the girls). The girls needed to resolve their ambivalence to their mothers, avoid being frightened by or identifying with their mothers' weakness, love their mothers in spite of it all, and not to identify with their fathers' strengths without becoming masculine themselves.

For the therapist, this patient-theme leads to reactivation of her feelings about her identification with her maternal parent. Thus, the therapist's self-experiences revolve around her own identity and role, and her variation of herself as a woman and as a professional.

C touched on a recurrent theme in the interviews having to do with the therapist as role model: "I served as a model to them of a woman who could be feminine and still be achieving." Role modeling of this kind serves to clarify the mixed messages which women patients may have received from their mothers.

Women become afraid of those strivings which they consider to be masculine. Such strivings are viewed as unacceptable and, thus, cannot be easily integrated into the self. C described her efforts to help her patients resolve conflicts about their female identification. She also commented on her own uncertainties with regard to her identity and how, through the work with one female patient, she got in touch with an aspect of identity confusion associated with ethnicity. She was able to identify several issues related to difficulties she had experienced in the separating from her mother:

> Every bid my patient made to individuate, to be different from her mother, caused her mother to get sick. And of course that reminded me of my own mother. When I went into my career she got a bleeding ulcer. Every move I made in the service of individuation was like a cardinal sin. And so this female patient reminded me of myself, and of the girl I would wish to be. So I helped her to realize herself as my mother could never comfortably help me.

C goes on:

> I guess in helping her [the patient] to individuate from a controlling, martyring, self-sacrificing mother, I identified with her to an extent, I'm quite sure, and I maybe further freed myself in the process of freeing her.

Herein lies the repair, the learning and the growth for the female psychotherapist. This was a consistent element in many of the interviews. C further reflects:

> When I said that in the countertransference she was very much a daughter to me, and it was reparative, what was hardest for me in my life was not having a child, and it was reparative to the extent that I would do for this child what her mother could not do. I was so proud of her and I got my wounds healed. O.K., you don't have your own child, but you can still contribute to the next generation, which is part of what you need to do. I don't know if that is good or bad, but it happened for her.

As in other interviews, there is, here, a mutuality in the growth process for both the patient and the psychotherapist. It appears to occur when the therapist is open to the self-learning which is possible as their own countertransference is evoked.

In helping female patients to achieve a sense of their own identities and to emerge into the world in a self-realizing manner, it is clear that many of the female therapists have experienced a maternal countertransference. By gaining awareness and insight about their countertransference through their own participation in a depth psychotherapy, women therapists can greatly promote the successful treatment of their female patients, as the therapists in this study were able to do. C said:

> If I hadn't been aware of my feelings toward her, I could have derived too much self-satisfaction out of being her model, and gotten in the way of my patient's picking up what was positive in her mother. In order to be a whole person, she has to selectively identify with her mother. If I stand in the way of that, I am doing her a great disservice. So I have to back off--it is not my child.

Most female psychotherapists in the study felt as Q, C, M, and T did:

> You have to have somebody who is going to be there and hang by you whether they are angry with you or criticize you, but they are there. We are going to be here when you make mistakes, and we may tell you about them, but we will be here. We are rooting for you and encouraging you, but whatever you do is your choice.

## Theme 2:

## Fear of Success

Data from the interviews with these therapists (M, T, and E) are presented to illustrate selected aspects of Theme 2, Fear of Success, in the countertransference. The five aspects of this theme are overlapping, and therefore are not amenable to truly independent presentation, although subheadings within this section may so imply.

These presentations illustrate how much fear of success is associated with early maternal messages about ambition, achievement, assertiveness, creativity, intellect and self-esteem. As in the preceding section, the therapists' countertransference issues about fear of success run in parallel to the conflicts and issues being explored by their patients.

## Conflicts about Ambition, Achievement and Assertiveness

Therapist M presented an Asian woman, a physician in her early thirties. The patient was brilliant, markedly shy, and inhibited. She had just begun a private practice with a group of extremely high-powered, achievement-oriented, physician colleagues. The patient felt lost and confused about the enormous difficulty she experienced in her professional work. She felt perplexed about her own behavior because, although accustomed to considerable responsibility, she found herself procrastinating and feeling inferior to her colleagues. Most of her work in therapy centered on her confusion and work inhibition, and on the question of whether she could continue in private practice or even the field of medicine.

Exploration of this patient's conflicts focused on her relationship with her mother, an Asian-American socialite married to a prominent businessman. The patient's mother had expected her daughter to attend college in order to find a suitable husband. The patient was encouraged to date, to have many boyfriends, and to be popular rather than to get good grades. Although encouraging her daughter to pursue relationships with eligible men, the patient's mother disapproved of sexual activity. On several occasions, she accused her daughter of becoming too intimate with men. The patient eventually married a

successful business executive. However, when she entered medical school, she and her husband divorced because he did not want an ambitious, independent wife.

Therapist M's own conflicts about intelligence and professional achievement were evoked when the patient described having achieved more recognition than her husband. He had become so threatened by his wife's accomplishments that she became fearful, thereafter suppressing her knowledge and skills. In time, she had become merely an adjunct to her husband, rather than allowing her own talents and capabilities to emerge.

As the patient described her relationship with her husband, M was aware of her own intense feelings and conflicts. When the patient described herself as immediately dependent and demanding in her relationships with men, M recalled her own confusion in similar situations. M at once acknowledged and resented her dependence on men, realizing that she wanted to be more than "the wife of" somebody. Like her patient, she wanted an identity of her own. Yet both M and her patient sacrificed their talents, intelligence, and ambition to avoid threatening particular men, hoping, thus, to preserve the relationships.

Further therapeutic work revealed that M's patient wanted very much to be the beautiful Chinese-American

princess in her group medical practice. She wanted her partners to help her, praise her, and adore her. Consistent with her mother's wish that she should remain a beautiful object to be adored, helped and taken care of, she did not want to be forced to perform on her own. Nevertheless, she selected M as her therapist because, as is often true, she wanted a strong woman role model. M's patient said to her, "It is clear that I chose you because you are female, professional, successful, achieving, and obviously not in the dependent role that my mother is in, or that she sees me as being in."

M described a related issue having to do with her patient's inability to initiate her own work. When work was scheduled or assigned by someone else, the patient responded with alacrity. However, if there were no immediate deadlines, if she had to take initiative and use her own creativity to explore and develop plans for professional work, the patient found herself confused and unclear in her approach. In contrast to school situations where she had loved debating and doing creative research, the patient became embarrassed when called upon to present her work at professional staff meetings. As she explored these difficulties in therapy, the patient became increasingly aware that private practice required her to behave differently. Her current work required

initiative, assertiveness, and a willingness to be highly visible in professional situations.

Concurrently, M realized that she saw in herself conflicts similar to those in her patient. M reflected on her own discomforts with ambition, aggression, innovation, and creativity. She noticed that she had not been working on several articles she had agreed to write for publication more than two years previously. Even with a deadline finally set, M, like her patient, found herself procrastinating. After some reflection, she recognized she felt uncomfortable assertively stating her own ideas and leaving herself open to public scrutiny and possible criticism. She noticed that these conflicts were similar to those of her patient. In the ensuing exploration of the sources of these conflicts, M reflected upon the mutuality of learning for both her patient and herself. Both moved beyond their own inhibitions to an in-depth realization of how afraid each had been to hurt or devalue their mothers by failing to live out their mothers' messages.

M, like many of the therapists in this study, had a maternal countertransference to her patient. She felt fond of her, wanted to help her grow, and reflected:

> I have a lot of pleasure in working with her. She's bright, articulate, interesting. I like to see her grow and, most importantly,

> many of the conflicts she's working on are conflicts I've had to deal with myself. I am a woman, and some of her conflicts about how she wishes to be different than her mother are things I have felt myself.

M continued by speaking of her own very traditional Asian mother. Although more ambitious than the patient's mother, M's mother was born in Japan and emigrated to America with her very traditional Japanese husband. M's mother, though extremely bright, was unable to develop a career. Her considerable intellect was therefore channeled into writing speeches for M's father, a prominent member of the community. She also took great pleasure in the academic achievement of her children. M reflected on this:

> I've often felt guilty, conflicted, like I was betraying my mother as I went ahead in my professional career. But another part of me felt that she really would have enjoyed seeing me do all of this. She would have gotten vicarious pleasure in my achieving. And I think, in that sense, it's quite different from my woman patient, because I think for my patient's mother, it's very threatening to see her daughter achieve and do well. She's proud of her in one sense, wants to show her off and say, "Look at my daughter, the doctor," but she's quite envious and uncomfortable as her daughter becomes successful, aggressive, and self-sufficient. I think she feels intimidated by her daughter, worries that she no longer has any control over her, that her daughter will leave her, not take care of her, do for her. My own mother was more subtle. Her fears were not the fears that I would leave her, but that my role was properly first and foremost to be successful as a mother and as a wife to my husband.

In summary, both M and her patient were raised by their mothers to be "good wives," and both needed permission to attain recognition for their own achievements. Professionally, both patient and therapist found it difficult to take the initiative and to be assertive. Both realized that they were reenacting roles prescribed by their mothers--the helpless, confused, not-too-bright, disorganized, dependent little girl. Their shared major conflict was wanting fully neither the role of beautiful, successful housewife and mother nor the role of independent, successful professional woman. This interview demonstrates how closely the issues of patient and psychotherapist may parallel each other. Because of her attention to her countertransference, M was able to rework significant parts of her relationship with her mother. M recalled:

> Each step of the way up toward professional advancement, I felt conflicted about whether I should go ahead. I had a recurrent fantasy in which I am talking to my mother, justifying to her reasons for my going ahead. I am aware in this fantasy tha I wanted her permission. The reason I need her permission is that my mother was an ambitious woman, but she was born into a culture in the 1900's when women were not allowed to fulfill their potentials. When she would feel badly about not being able to be productive in a profession of her own, my father comforted her by telling her that the job of raising five children was the most important job for any human being. So in my fantasy, I assure my mother that I am still going to take care of my family, and then I'm aware that my mother is pleased and proud of me.

Subjugated Aspirations

As her "case," Therapist T presented a comparison of two women patients whose shared issue was fear of success. T used the comparative case presentation as a starting point for discussing her own fear of success. The two patients were from markedly different sociocultural backgrounds, but each struggled with similar issues about success and their fear of independence.

"Fran" grew up in an upper middle-class, high achieving family characterized by great sophistication and culture. She had earned a master's degree, and was exceptionally bright and highly articulate. She had aspirations of becoming a writer, but did not pursue them, choosing, instead, to remain a low-paid receptionist in a movie studio.

In contrast, Louise grew up in a lower middle-class family. Her father had emigrated from Greece while her mother, an American Indian, had lived on a reservation until she married. Louise had finished high school when she entered therapy. She was married and worked as a scretary, a "demeaned position" in which she felt terrible about herself. Despite her obvious excellence, she regarded herself as terribly inept.

Both women were in their late twenties, and were unhappy and depressed. Their self-esteem was very low;

they saw themselves as unattractive and unintelligent. T felt that both wished to remain inadequate and depressed instead of successful. She observed that they seemed to sabotage themselves each time they had an opportunity to advance. The turning point in treatment came when each began to recognize that she sabotaged, undermined, and created barriers to her own personal and career growth. T described the family dynamics which encouraged these patterns.

Fran's mother was bright and talented. However, she focused her talents and energy on her husband and children, around whom her life revolved. As the youngest child, Fran was indulged, but recalled feeling that, whenever she moved to take a step forward, she would be left alone and would die.

Louise's family was also large. All of her siblings continue to live in the neighborhood near their mother's home. Louise alone was able to leave. She did so by accepting the studio position as receptionist. Still, she felt afraid to be separate from her mother, as well as shame and guilt that she wanted more, and had fared better, than her family. She worried that they were envious of her.

T felt great empathy with these two women because the conflicts, fears, and barriers which precluded their

creativity were intimately familiar to her. She elaborated:

> In my own analytic treatment I realized the sources of my lack of motivation. I was interested, but the involvement necessary to have an in-depth interest was not there . . . . Many years later in my analysis, I came to understand that it was dangerous to get too interested in anything because that would take me away from my mother. As a child, it was just me and my mother, and it was a very intense relationship. She would travel a lot because of her business career. I felt I had to sit and wait for her attention, for if I were to go and get involved with something else I'd miss that attention. She would also be upset if she decided that this was the time that she wanted to spend with me and I wasn't available. Then she would get angry and withdrawn. So it was a big risk for me to go off and get interested in anything else. To this day, if I am out there too long, I begin to get anxious. So for me, as for my two women patients, it becomes how do you dare to separate from your mother? What is going to happen to you? I guess the feeling that we, my patients and I, struggled with was we would die.

T experienced a reactivation of her own separation-individuation conflicts with her mother. At times, she recalled, she would have a desire to step out of her therapeutic role and had the impulse to say to her two patients: "Look, I know just how you are feeling, and I'm telling you that if you take this step you will feel so much better. Stay where you are, and it will make you feel depressed." Nevertheless, she knew how important it was to maintain a neutral position, to avoid intruding in her patients' transference. She commented: "We must

sit back as therapists and let it unfold. There is no way you can tell somebody and have it mean anything--you have to allow it to unfold so that they can experience it."

Both patients, having worked with their guilt, their fears, and their conflicts, went on to very high-level executive jobs. Fran manages a government environmental protection agency; Louise is the vice-president of a publishing firm. The therapeutic experience with T allowed both of them to develop their potentials in accord with their own desires and choices.

Several therapists interviewed in this study indicated that, besides consistency, a sensitive woman therapist brings an unwavering, therapeutic optimism to the treatment. The therapist is confident that treatment works because of her own experience in therapy. Thus, the therapist offers to her clients what has been given to her in her own therapeutic treatment. Her enthusiasm communicates, "I'll hang in no matter how long it takes, because it will work, and I know it can work." This form of encouragement in the transference relationship adds to the clarification of many anxieties associated with the fear of success.

Inhibitions in Creativity

The interview with Therapist E was unique because she focused specifically on the creative process in her patient and herself. The case which E discussed was of a woman writer with creative inhibitions. The writer came from a familial milieu which, like E's family, had been insensitive to her creative aspirations and had nearly stifled them with indifference. E's treatment of this patient revealed to E her wish to free her own creative process. In her own analysis, ongoing during the time of this patient's treatment, E was able to thoroughly explore the countertransference issues which the patient evoked.

E's patient was a 28 year old drama student who could not sustain relationships with men and who alienated friends. E described her as having developed an idealizing parent-imago transference to her. The patient was narcissistic and vulnerable. Both parents worked, and she grew up feeling alone and isolated. By using E as a self-object, she was able to grow considerably during treatment.

In reflecting on her feelings about this patient, E said, "There was something undefinable that was special in terms of my feelings about her." As a form of special encouragement, E brought her patient a small gift from a foreign country; the gift was relevant to the profession

to which her patient aspired. E described her behavior as unusual because she did not make a practice of bringing gifts to her patients. Later, during the interview, she realized, from her inner experience, that she had wanted the patient to know that she, E, could understand and encourage the patient's creative desires and pursuits. E recalled, "Running into my own superego types of restrictions, I shouldn't have brought her a gift. But I felt it to be meaningful and right."

E also described the conflicts she experienced about allowing her patient genuine choices. While struggling with her reaction to the patient's fundamentalist religious convictions, she realized the strength of her own commitment to allow people their own attitudes and thoughts even when hers differed from theirs. This struggle with diversity evoked painful memories of childhood in which E recalled she had been made to feel "weird" or "strange" because her need for creative expression differed from that of her stolid, prosaic, middle-class parents.

E presented this patient in the interview because, as she remarked, "There were more issues parallel to mine: some countertransference issues which were immediately paralleling--and I wanted to look at them." The parallels had to do with E's past. She had been extremely inhibited, had felt grave difficulties in expressing her feelings,

and had felt a creative inhibition as well. She understood her encouragement of her female patient in terms of her own past: "I felt totally alone, as if no one quite understood me for who or what I was. No one understood my creative, sensitive part." She reflected further on her development within a family which neither recognized nor encouraged her talents:

> My music teacher had to tell them how talented I was. My mother would go to the concerts, but she would not read the program notes. She was never really involved in the concerts, or in that part of me.

Similarly, the patient's parents could not understand the patient's need for creative expression through writing. They were unable to become involved in or to help the patient achieve her creative aspirations. While they were interested in achievement in general, they were not especially interested in what she was learning, or what the learning meant to her. The patient felt invisible.

E had strong feelings of empathy toward this patient, derived, she acknowledged, from her own similar feelings of deficit. She was acutely attuned to the patient's need for support, although the patient's parents had not been. As her own music teacher had been, E became a kind of mentor for her patient, discovering, encouraging and enhancing the patient's creativity. E said, "I'm sure

I would have been a different person if it had not been for her, because she was there, she did understand, and she did mirror me; and I idealized her." E passed on to her patient the gift she had received from her own teacher: the ability to value herself, to lend credibility to her creative part.

E reflected on the uniqueness of a shared understanding of the creative process:

> There was something about that mutual kind of creativity, you know, that part of us that is common among artistic-type people that does not necessarily have to be verbalized. There is something that is "metacommunicated" to each other. It is like being in a special kind of family which most people could not understand, but we do, intimately.

One might infer from this comment a struggle which E could have felt between her "therapeutic superego"--the values of her formal training--and her deep, intuitive feeling of what she should do with her patient. Indeed, the author feels that experienced therapists may often surrender their most creative techniques in treatment in order to follow earlier, learned values of the profession. The risk in not doing so is to be labeled a heretic, which can, itself, lead to the constriction of creative ideas. Thus, one must ask what, in a therapeutic situation, a woman therapist's creative inhibitions might include.

Conversely, one can ask what conditions the therapist might need to meet, in order for therapy to be described as a creative process. If the therapist's resonance is tied closely to an understanding of the transference and countertransference issues; if the therapist allows respect and permission for differences; and if she encourages mutual discovery, including an emphasis on the free flow of curiosity and fearless pursuit of ideas and issues; then psychotherapy can be characterized as a creative process.

When a woman therapist works with a woman patient who presents conflicts leading to creative inhibition, the woman therapist may also be offered the chance to rework similar aspects of her identity, both as a woman and a profession, through the patient's process.

## Theme 3:
## Role Conflicts

Major themes emerging for the therapists in these interviews related to their conflicts in balancing career aspirations with family and social relationships. Further, they described role conflicts related to societal definitions of masculinity and femininity. These emerged in relation to the ambitions of certain patients and therapists with resulting confusion related to traditionally proscribed behavior for women.

Masculinity versus Femininity

While the majority of therapists in this study emphasized their intrapsychic conflicts and those of their patients, Therapist I focused more on the continuing sociocultural dilemma of masculine and feminine stereotypes. In her case presentation, I described a young, female patient who had suffered severe losses (her father, brother, and husband) and who had also experienced early narcissistic intrusions. I's interview highlights the way in which role conflicts about masculinity and femininity contribute to later inhibitions and fear of success.

I's patient was a highly intelligent woman who, having been rejected by her mother, had essentially reared herself. Her behavior was often self-defeating. One defensive aspect of the patient's character, which I found most irritating, was her presentation of herself as an "ultra-pleasingly-sweet woman." This false self was, the patient felt, the only socially acceptable way to gain approval, especially from men. The patient was a subjugated woman. I, in turn, was well aware of her own difficulties in dealing with "sweet girl" women, rather than the defiant, rebellious, struggler with whom she could more readily identify.

In the interview, I described her awareness, in the countertransference, of her wish to deflate the "sweet, beautiful, ideal balloon," while simultaneously acknowledging that she had learned more from this patient than from many others. I commented on how essential it had been for her to sit back and allow this patient to unfold in her own time. She said:

> I think one of the major problems we, as women therapists, have with women patients is when we identify and, therefore, want to encourage their assertiveness too quickly. That's more in the service of our needs, not necessarily theirs.

I related this insight to her own past dynamics, especially to feelings of passivity and timidity. Since repair occurs when the therapist helps her patients to emerge, to free themselves for creative and productive pursuits, the temptation is to move too fast. I said, "I must guard against pushing too quickly and question who I am really pushing."

I felt concerned about her patient's ambition and aspirations. She commented:

> I think the fact that she seemed to have so little ambition was a big mystery for me. Somehow, in this bright woman, who could have been anything she wanted, she wanted so little for herself. Somehow, her ambition got stopped!

I and the author together commented on how often they had been amazed by the lack of ambition or aspiration in

certain of their female patients. I said of her patient, "She talks about wanting her life to change, but she does not aspire. It offended me! Where is her ambition?"

The author here infers an aspect of hidden countertransference. While one may argue that in every person, male or female, there is a "budding somebody," the therapist must be aware that these feelings may be her own repressed aspirations, strivings, and ambitious yearning to be freed, and, in some cases, not those of her patient. The danger in this particular countertransference issue is the therapist's inability to differentiate her own projection from the patient's reality.

A number of therapists made observations which summarize the issues of masculine versus feminine role stereotypes. P questioned whether women had made real progress, or whether they might feel worse now than several years ago because the sociocultural conflicts are more apparent. Although women may be aware of more options for themselves, it is not automatically the case that they can achieve or maintain them. Therapist O added her own observation that, while women have achieved more professional, intellectual, and academic parity with men, they still bear the principal responsibility for home, children, and family.

Role Models

Women need a particular kind of role model in other women. Often they seek out and select certain women therapists because their professional stature is combined with femininity. In several interviews in this study, therapists indicated that their female patients had specifically chosen to work with therapists whom they know to be married and the mother of children. Therapist M indicated that the patient she chose to present had, in part, selected her because she was married. In describing her patient, S said:

> She felt that with me she had a chance to be both successful, professional and feminine. She saw me as a more feminine person than the other analyst, and fresh flowers in my office had a great deal of significance for her.

Consistently, the issue of role modeling has been linked with the need to achieve some balance between professional and familial priorities. Thus, it, like many secondary themes, is better illustrated in connection with material concerning family versus career role conflicts.

Family versus Career

Therapists A and T discussed the role conflicts they experienced in their need to balance family and career needs. Both A and T had children under 12. A talked about the emerging guilt she felt in balancing her

familial/mothering roles with her role as a professional woman: "I feel guilty if the balance gets tipped. If I am away from home or too involved with my work I get confused: am I going to do to them what my mother did to me?" T described her feelings of conflict about the attention given her child versus her patients: "Sometimes it's hard to give to both. I feel like I'm not a good mother to either one."

A speculated that, perhaps out of their own deprived childhood expectations, or perhaps because of traditional role expectations, professional women have had to struggle with role conflicts distinctively different from those experienced by men. She identified these as a balancing act between mothering and a separate professional role. Women therapists are in a doubly difficult position, as they struggle not only with sociocultural and familial pressures, but also psychological conflicts.

Therapist M's experience with her patient is a good illustration. M presented the case of a 35 year old woman who expressed both the wish to have a child and some trepidation about it. The patient believed that she was reaching the age when the choice would be taken out of her hands. She wanted to strive for rapid advancement in her profession, feeling the need to recover lost ground from a marriage which had held her back. She had

many friends, and had recently met a man she liked. She felt conflicted about the offer of a professional position which would have conflicted with the new relationship. She felt forced to make a choice between the relationship and her career aspirations.

M's patient feared committing to a career because, although she was brilliant and successful, she feared a further loss of relationship. She raged over the time she had wasted in her former marriage, and was eager to move forward again. M identified with her patient's longing to have both a career and a rich relationship with a man. She recognized in herself the patient's confusion about what she saw as masculine (career) and feminine (husband and family) aspirations. The patient had tried to solve her dilemma by stifling all her drives and abandoning the wish to get ahead. Professional success, to the patient, meant that she was masculine, aggressive, and "forever an old maid."

M said:

> It stirred up all kinds of thoughts about how I was happy that I did have children and that the experience had been wonderful for me. In my countertransference, I experienced a kind of hopeful wish that the same thing would happen for her through this therapy. If it was something that she chose or wanted for herself.

In this interview, M alludes to the rigidly defined cultural roles transmitted by mothers who felt themselves

to have few options other than to be traditional wives and mothers:

> This person's mother, of course, was of a sociocultural background where a woman raised her daughter with one intention in mind--to marry, and to marry well. She was raised to be junior league, to be charming at parties. There was never any response to all her giftedness, capability, and capacity. She saw her mother revolve around and serve her father, thought this was what a woman should do in a marriage, saw her mother serve her father, and work from morning till night to please him. She saw this as what a woman should do in a marriage, and despised it.

Therapist S's patient is a good example of the way women subjugate intellectual and productive talents, an ingrained part of culturally imposed role stereotypes. Within women, the conflict is intrapsychically structured so that, when they experience enormous barriers to aggressive and productive strivings, they are unable to locate the origins of their guilt, unease, and uncertainty. While talents and capacities are constricted, they remain subservient to spouses and tied to children in order to preserve important relationships.

S's woman patient had learned to hide her enthusiasm for her professional career, and her advancements in it, when she was involved in a relationship with a man. Following in her mother's footsteps, she had served the man she married. After exhausting herself to please him,

she was appalled when he suddenly announced the marriage was over. In reaction, she blamed herself for being insufficient and a failure. S reflected, "This material was stirring for me. Certainly, it would be for any woman in our day and age."

S quickly became aware of her desire to extricate her patient from the internal and external prison she felt caught in. However, as S commented:

> I knew I had a positive wish for her, but I also knew that it must not pass the boundaries of neutrality. I could also have slipped into the shoes of her controlling and intrusive mother, were I to lead her in any way, even away or on a path which might seem more beneficial to her.

Because of their own life experiences, therapists L, O, and S had deep empathy for their patients' need to make their own choices. All three therapists had high-powered, achievement-oriented career mothers whose only anxiety was that their daughters not be traditional women. Their daughters had opted for careers which balanced the professional with the feminine aspects of themselves. One spoke of being afraid to be too career oriented. Another spoke of enjoying the creativity of raising children, which her mother decried. Yet another said, "Career is fine, but I don't want to miss relationships as my mother did, so I try to balance as much as possible." All three therapists spoke of their commitment to allowing

their patients the time and the space to make their own choices. L, O, and S felt they had been denied similar opportunities in their own upbringing. Thus, they felt it essential that their woman patients unfold in their own way and grow in their own way.

Therapist S said of her patient:

> She clearly had the unconscious wish to grow again, and I wanted to help her do it. I recognized two parts in her. There was the part that needed to be dependent and grow, to be close and experience tender feelings and not feel suddenly abandoned. And, there was also the part of her that needed to accomplish professionally.

S also saw those two parts in herself, as she confronted the problem of helping her patient to reconcile nurturing and dependency needs.

S and her patient amply illustrate conflicts between dependency needs and autonomous strivings, as well as maternal identification and repair issues. S described her own inner experience:

> I always kept a very high regard for her wish to be successful professionally, and to do what she needed to do for herself. But within me there was something that resonated with her and I think it came out of a sociocultural position. She <u>needed</u> to be successful, but whatever she wanted or needed I would respect her choice, and be there for her needs.

When S's patient struggled with getting married again, and perhaps having a child, S recalled feeling all kinds

of questions. Along traditional, "how-wonderful-for-her to-have-children" lines, S commented that she had felt, "Wouldn't it be nice for her [the patient] to get married, have tenderness and closeness, even marry her prince?" Upon reflection, however, S had reconsidered: "Now I feel very differently. Not every woman has to marry, have children, and a home in the suburbs. I feel that what she chooses to do, she will do, and that she will make it in a way that she needs to make it."

The extent to which a therapist is able to look at her own feelings, allow for her own inner experiences, live with them and, therefore, grow within the process seems to be the extent to which the therapeutic endeavor will be a rich rewarding and creative one for both patient and therapist. S, in this regard, said, "I had to be so very aware of my own countertransference at all times, partially because I was so identified with her, partially because one would have to be, at any cost."

Many of the therapists, and the author, wondered if the extent to which a woman therapist has balanced her professional and relationship needs will influence the course of the treatment with her women patients. The therapist speculated that the issue is not so much how well it has been balanced, but how in touch the therapist is with the constantly changing and fluctuating balance.

She also emphasized how necessary it is for therapists to be aware of their attitudes toward that balance. She commented that a therapist must be aware of her changing needs and values, because her attitudes about the balance will not stay the same. As a woman goes through various life stages, the balance of career and relationship needs will change for her, not necessarily predictably, but at least perceptibly.

## Theme 4:

## Envy in the Countertransference

Envy in the countertransference was associated with the reactivation in the therapist of dependency wishes, conflicts about autonomy, and mourning for lost and absent opportunities for gratification.

Six psychotherapists (A, C, E, H, P and R) related their feelings of envy in the countertransference to their patients' ability to be dependent. The therapists felt envious that they were not allowed the same luxury. Therapist C said:

> I always felt so cheated. My father was so incompetent and my patient had a father who was an extremely competent, professional man. She had everything, not just material things. There is a feeling of security when you know there is even one parent that will not let the household down. That you don't have to go to work at an early age as I did just to have spending money.

Therapist E's envious and competitive feelings were aroused not only by her patient's gifts of expression, but also because of the considerable help and support which her patient was receiving while writing a Master's thesis. E recognized that she envied her patient both for being well taken care of and for receiving the special interest of many people. E also felt that she was aware of her envious feelings and "on top of them," so she could feel admiration for her patient as well.

Therapist A's countertransference envy was elicited by her "little girl" patient whose husband doted on her and adored her. A described her patient as "his little child bride" although the patient was 32. Not until the patient's poised, calm, practiced, socialite facade gave way to reveal the needs inside, did A begin to resonate with this woman and feel involved with her. Several other therapists expressed similar difficulty with certain women patients. Some described themselves as angry, only later becoming aware of their envy. Only as envy was recognized could these therapists continue to work with their patients and help them to reveal deep inner feelings and needs. A said: "I felt envious of her relationship with her husband. This guy would walk through fire for her. She could do no wrong."

A's envy was related to her own feelings about dependency and autonomy. Three other therapists (H, P,

and R) described similar conflicts about dependency in relation to envious feelings they had about certain women patients. Sometimes this envy was evoked by women whose husbands doted on them and took care of them, fulfilling the traditional role of caretaker, provider, and "strong father figure." A reflected upon her reactions to her woman patient whom she described as severely sexually inhibited. She had said to herself, "You lucky thing, to have a man like that, enduring like that." However, she had also promptly told herself, "Now look, you, don't let my envious countertransference rock the boat of this marriage."

A explained her own envy of her patient's infantile behavior:

> It's because I'm a very independent person, independent because I had to be in my life, and I've never had an opportunity to be a baby, nobody ever indulged me. I had to grow up fast and do it on my own!

When another therapist, H, described a woman patient with high professional expectations of her male boyfriend, H reflected:

> I admire and envy her ability to expect of him that way. I would have liked my husband to use his talents more; maybe he could have taken care of me, and I wouldn't have had to work so hard.

Several therapists described their envy that patients received narcissistic supplies from them, and envy of the good mothering they were giving their patients. One therapist said: "What we seem to need in return are dreams, and possibly the feeling that we can see them [the patients] realize something from us."

When the author asked why A chose this particular woman to present, A responded forthrightly:

> I chose her for the opportunity to talk about her and articulate both the envy I felt and the investment I had in her. I think my resentment was of a woman who enjoyed all those things "feminine," in terms of being allowed dependency that I was denied, and yet was also deprived of the opportunities that I had to become a person. I suppose my need to see her become a whole person has something to do with my need to affirm to myself that those women who were allowed to be dependent did not have a better deal than people like me.

In contrast to A, Therapist R's issues of envy in the countertransference were associated with competition and intellectual excellence; maternal identification and the maternal relationship; fear of success, reflected in conflicts about intellectual exhibitionism and inhibitions in creativity; and mourning.

R described her patient as an exceptionally bright environmental physicist, the highest ranking graduate from a local university. R's crucial countertransference issues included her competitive and envious feelings

toward this woman and particularly toward her patient's intellectual achievements. R states:

> My envious feelings focused on her youth and the opportunities open to her, because of the constellation of dynamics that left her unconflicted in areas that were conflictual for me--for example, in the area of intellectual exhibitionism. And also the greater freedom that was afforded her by a society which, today, has to some extent widened its horizons for females. She was moving ahead in her mid-twenties, while I, so many years later, was plodding through areas that I wish I could have plodded through in my mid-twenties.

R's comments include an element of mourning for her own lost opportunities as well as envy. Thus, envy can be seen to lead to mourning, especially when, at a mid-life point, this therapist has had to reflect upon what, in retrospect, she wished she had.

Therapist C and several others, like R, grieved for the losses in their lives, and envied their patients' youth. Yet while mourning for those things they had not had in their lives, these therapists were able to take comfort in what they had helped their patients to have. Therapist C, for example, experienced bittersweet feelings when her patient finished medical school: "I always hoped that my daughter would make it, but now she [the patient] got there, and it gave me a feeling of fulfillment." C's comment illustrates the care which therapists must take so that their own needs and issues do not negatively affect their treatment of patients.

R's envy is also related to the fear of success. When she speaks of creative inhibitions, she refers to the blocks which both men and women share, and which impede their movement into productive expression of intellectual and aesthetic capacities.

R indicated that her patient, to some extent, provoked envy. The patient had a natural confidence, had achieved success in her profession, and had won awards for her professional work. R added:

> All of this stirred up intensive reactions in me. Characteristically for me, I responded with maternal feelings, part of a defensive maneuver against the competition and envy, but in part they were also precursors to adopting a genuine facilitating mode.

R vividly described her inner experience during the interview, often with tears. At one point she observed:

> This case enabled me to identify the areas in which competition and envy emerge for me--not only in this case but in other areas of my life. My envy never emerges from feelings about people's relationships. It is almost exclusively in some area of intellectual achievement; it is seldom in the area of money, seldom in the area of envying a special relationship someone could have with a man. This case crystallized that realization for me, which had never really be in the forefront of my consciousness.

R also recalled the early genesis of her own intellectual inhibitions: "My envy or competition is toward the ease with which my colleagues can display what they

know, or their apparent confidence that whatever intellectual or verbal production they would put forth would be welcomed and well received." The antecedent of the therapist's discomfort in the area of exhibiting derives from her relationship with her mother.

R has highlighted what this author believes is a partial core of intrapsychic inhibitions for many women, that is, the dynamic reasons why they depreciate themselves. R recounts:

> My mother was simply indifferent in those areas of intellectual achievement. She wanted me to get an M.D. or Ph.D. without any concomitant reinforcement from her. I should do this magically on my own, without any help from her . . . and in the end I would get a good degree, marry well, and take care of her. My father, threatened by my intelligence, was indifferent towards my intellectual achievements. More separation has to take place in order to free myself from both my mother's indifference and neglect and my father's threatening behavior. As I continue to resolve these areas, my envy or my feelings about my patient reduce. I'm very aware of them, and am clear that my role as a facilitator is not a defensive one. The more I clear up for myself, the more I become comfortable with her, and see her more as she really is with her own conflicts.

Implied in this statement is not only the power of the countertransference experience, but also the imperative that therapists have access to, and use, psychoanalytic treatment for themselves. When the author commented that effective treatment would require the therapist's

close attention to the defensive functions of her counter-transference, R responded:

> It was crucial to effective treatment . . . I would not be able to make proper interventions around her [the patient's] conflicts because I would not see them as conflicts. I would not see them as problems for her so I could not be effective at all unless I had that aspect of myself analyzed.

Often, during the interviews, the women therapists compared themselves with their patients. R commented:

> It makes no sense, really, because of our differences in age, the different cultures we grew up in. We're years apart, but dynamics are dynamics, and there is a universality, and that is the common bond. I don't know how much I've learned through this patient about myself, but I have come to a greater sense of respect for the unique and individual struggle one has in one's own life, and the unfolding that really defies comparison with any other person--even with one's peers. What is most difficult for me with my woman patient is some of the mourning process I am going through, along with other issues of what never was and what never will be.

As she concluded her comment, R began to weep.

## Theme 5:

## Life Stages

### Mourning

As described in Chapter IV, mourning is viewed in this study as a process emerging naturally in the mid-life, reevaluative phase of both men's and women's lives, and as arising out of envy in the countertransference.

Many of the therapists interviewed had reported counter-transference envy of their women patients' intellectual achievements, youth, options, exhibitionistic freedoms, and dependency gratifications.

Envy, then, opened the door to mourning associated with mid-life: the intense experience of pondering and reflecting upon the changes in the psychotherapists' own lives as well as grieving for what they had not had and in some cases, would never have. Mourning was able to lead psychotherapists to an important transformation: they became able to express admiration for their women patients. Further, they felt a sense of gratification that they could help their female patients to achieve in areas which either had not been open to them, or in which it had been difficult or impossible for them to realize their own aspirations.

The interview with Therapist P, like many others in the sample, illustrates the work of mid-life mourning and working-through of the therapist's own life experiences. The majority of the women psychotherapists in this sample were experiencing a similar phenomenon.

The mourning process was described poignantly in Therapist P's account of her intense inner responses to her patient's youthful and flowering life. The interview not only highlights the mid-life mourning process, but also describes a set of traditional role conflicts

and stereotypes which had contributed to a feeling of construction for P. P recalled that abundant options now available to her woman patient had not been open to P's generation. (Therapists H, O, R, and T echoed the same sentiments.) P had felt deprived of options and this contributed to her grief within the mourning process.

P presented a patient in her early twenties who had just had a mastectomy, and was experiencing intense depression and rage at the doctor for "taking away her body." The patient was in treatment for a period of three to four years, during which time she dealt with her depression and loss. The patient's father had been psychotic, while her mother was an extremely submissive, unambitious, traditional woman who, like the patient, was severely depressed.

At the time of the treatment, the patient was working on her doctorate. She had a poor self-concept, was alienated from both parents, and was angry both at her father's impulsive violence and at her mother's submissive attitude towards it. The patient felt alone and lost. Although she had rejected a traditional role, she now saw herself as being denied of feminine beauty because of her mastectomy. The patient's main dilemma, in fact, centered on her confusion about her role as a woman.

After helping her patient to repair the loss and work through her depression, Therapist P subsequently

helped her patient to clarify her goals and aims in life, to separate from her family and background, and to move towards "being her own person, and finding her unique way."

Therapist P sometimes had extremely intense feelings in response to this patient. P, too, had undergone a mastectomy. She felt empathy with her patient, understanding intimately the feelings of loss and depression after the surgery. Because P, too, had lost a part of her body, and grieved for the loss, she experienced rage at male doctors for their lack of sensitivity, their disregard for post-mastectomy emotional distress, and their overall lack of support. P helped her patient to ventilate anger, in general, and she was not threatened by the patient's transference anger toward her, understanding that it came from the patient's hatred of authority figures at the time.

During this period, P herself was going through a reevaluative phase of her life, questioning her life choices. She had concluded that, if she could live her life again, she would not choose social work as an occupation because of its low status and inadequate recognition. P, therefore, encouraged her patient to complete her doctoral degree in a more prestigious field.

The patient struggled a great deal with conflicts about wanting both a career and a family. Speaking from amid her own reevaluative period, P recalled she had

concluded that her own emphasis on family and children had been too great, and had brought her too few rewards. P indicated that, if she could have chosen over again, she would not have had children, and would have concentrated more on her career. Despite expanded choices for women in the culture, she questioned whether a woman could do justice to both family and career. Because women still take on greater responsibility for children and family relationships, P concluded that societal role structures are still prevalently opposed to careers for women.

In reflecting upon her own cultural imperatives, P saw that they had been marriage and family. Her parents had overlooked her intelligence and her potential in other areas. She regretted that options available to her patient had not been available to her earlier in her life. Further, she regretted the lack of a person to encourage her as she had encouraged her patient in treatment.

The patient, then, presented her own dilemmas, issues and conflicts which caused Therapist P to confront her own past. P, however, in her willingness and ability to face her own issues, did not have to avoid her patient's conflicts. Instead, she helped her patient while re-examining her own values, thinking and attitudes. Psychotherapy with this woman patient became a growthful experience for both of them.

The significance of P's life stage is illustrated by her reflections on mid-life, her reevaluation, mourning, and her integration of insights she gained in treatment situation with her woman patient.

P realized that she had, in the past, been far too glib in telling women patients--and herself--that they had as many choices as men. In looking back on her own life, she had neither realized nor wanted to admit how often she had sacrificed her own career wishes for the sake of maintaining a healthy family life. She was all too aware that her marriage would have taken a completely different turn had she not been so compromising, and had she done what she really wanted to do.

Mid-life

The theme running through J's interview centered on the therapist's stage of life and how it influenced and contributed to the patient's treatment. The point of paramount interest was how therapists transmit certain values, encouragements, and attitudes at certain phases in their lives, and how these may shift and change during another phase.

J presented the case of a 23 year old patient whom she first had seen seven years ago. The patient, a bookkeeper, was married to a man several years her senior

who had severe sexual problems. The patient blamed their sexual difficulties on her own inadequacy. Later in the therapy, after considerable work on herself and the realization that her husband was homosexual, the patient divorced him.

J found her patient to be extremely bright, humorous, and energetic. She looked forward to this patient's sessions and often felt stimulated as soon as the patient arrived.

J first saw the patient when the patient was 23 years old, and then again when she was 33 years old. In the interim, J herself had been divorced and had moved her practice to another state. When J returned years later and reestablished her practice, the patient came back to her for treatment. The patient's current conflict was whether she should concentrate on expanding her career or focus on finding a man and marrying again.

J was struck by the parallels she saw between her life and her patient's at each end of the ten year interval. When the patient had first come to therapy, J's personal issues concerned separation from her family and individuation from her husband. During this period, J encouraged her patient to "find herself," and viewed it purely as an effort to expand the patient's own productive and creative capabilities. J believed that her value

emphasis was entirely congruent with the patient's at that stage in the patient's life. In retrospect, J realized that this emphasis was her own value judgment. Thus, the "meta-internal" communication for her patient was toward the patient's career development. Although not overtly communicated to her patient, the emphasis on career and individuation was really J's message to herself at a particular life stage.

When she returned from out of state several years later, J felt alone and isolated and, hence, she also felt increased appreciation for family and friends. J became increasingly aware of her own needs for family support and, more generally, the role of family in promoting good mental health. Hence, her message to the patient--no less covert than before--stressed the importance of relationships and familial ties. This message was vastly different from the previous decade's clarion call to separate, differentiate, and move out into the world.

The advent of women's liberation and changing life styles had also influenced J's approach to her patient. J was especially sensitive to the changing sociocultural milieu's effect on single, divorced, or widowed women. In the first therapy 10 years years previously, J had encouraged her patient to break out of the symbiotic and constrictive relationship with her husband. J was

simultaneously engaged in the dissolution of her own marriage. During her more current encounter with the same patient, J indicated that she was more circumspect with reference to this particular issue. Values have changed in the outer world, and it is difficult for a bright, sensitive, middle-aged woman to find a spouse with similar attributes. Likewise, values have also changed in J's inner world.

Therapist H summarized her own sense, shared by other therapists in the study, of a life stage's impact on each person, but especially on the women psychotherapists in this study. She said:

> Perhaps at certain times in our lives we have needs that lean in one direction more than the other . . . what we must do is focus always on the impact of our own developmental stages on ourselves as well as others around us, and be aware that life is never static, nor are we.

Especially in their role as psychotherapists, all 20 women knew they needed to be alert to attitudes, opinions and ego-ideals shaped by their current stage of life. In their work with younger patients, many recognized that they were confronted with their own feelings of mid-life conflict during transition and flux of that life stage. By remaining alert to their own changes, they were able to respect the attitudes and choices of their younger patients. Concurrently, they were exquisitely attuned

to the issues and conflicts of women patients nearer their own age.

# CHAPTER VI

# DISCUSSION, CONCLUSIONS, AND IMPLICATIONS

## Overview of Dissertation

### Review of the Purpose and Objectives

The purpose of the study was to examine the consciously felt countertransference themes for women therapists in their treatment of women patients. Corollary questions concerned: (a) whether the themes were gender-related, and (b) the possibilities of mutual growth and repair for both therapist and patient through the therapist's attentiveness to her countertransference in the treatment of her woman patient.

The author postulated that no women in this society can avoid internalizing negative attitudes that have been part of the sociocultural milieu in which she was raised. These attitudes are transmitted and internalized during the earliest phases of her development, and within the most intimate framework of her object relations. They are then reinforced by the prevailing culture. The feelings that derive from these attitudes become reactivated in

the countertransference, leading to the dynamic interplay with the female patient, which is one of the focal points of the study.

Another focal point of the study is based on the author's premise that there is a mutual growth process for both patient and psychotherapist. This will occur if the therapist is open to self-learning through awareness of her own countertransference. More specifically, women therapists can learn from their women patients about their female identity, and about issues pertinent to being women.

Review of Methodology

Twenty analytically oriented social work psychotherapists were subjects in this study. They were selected on the basis of their qualifications as licensed practitioners, their having sufficient experience to utilize analysis of their countertransference as an essential contribution to analytically oriented psychotherapeutic treatment, and their having undergone analytic therapy themselves.

Semi-structured, open-ended, in-depth interviews lasting 1-1/2 hours were held with each therapist. Therapists were asked to present the case of a female patient with whom they had worked for a period of time. It was emphasized that the primary interest of the study was not the treatment itself but the therapist's own countertransference.

The interviews yielded raw data consisting of the self-reports of the therapists. They provided rich material based on the therapists' inner feelings, concerns, and conflicts.

After transcription, the author undertook a line-by-line review of the contents of the interviews. All subjective statements germane to the countertransference themes of the therapist were underlined. The therapists' statements were then grouped into two columns, one entitled "Major Themes," the other "Secondary Themes."

## Review of the Literature

The study attempts to consider issues related to two pertinent areas: (1) female development as it relates to women's issues and conflicts; and (2) the countertransference of female therapists in their treatment of female patients.

Attending the first area, Freud's theories of female sexuality (1925-1933) have been reviewed. Challenges and modifications to Freud's theories, as reflected by the contributions of Horney (1924-1935), Schafer (1974-1977), Galenson and Roiphe (1968-1977), and Stoller (1963-1972) were included. The contributions of Mahler (1963-1968) to understanding of early infant development, especially the phase of separation-individuation, form the overall base for this study.

With reference to the second area, selected contributions of Searles (1965-1981), Kernberg (1965), and Racker (1953-1981) on countertransference are used.

The literature on women's issues contains many surveys of the attitudes of psychotherapists, for example, orientation to psychotherapy, sex biases, sex-role stereotyping, and so forth. There are few studies using self-report data from therapists. This study goes beyond the more global surveys to an in-depth exploration of the feelings and conflicts of the therapists themselves.

The present study, examining the countertransference themes of female therapists in their treatment of their female patients, has provided material which will fill a gap in the existing literature. Brodsky and Hare-Mustin (1980) stated that research dealing with the feelings of psychotherapists was a vital and fascinating area for consideration, but one which had been most neglected. Searles and Lange (1981) also comment on the relative paucity of literature relating to the feelings of psychotherapists and psychoanalysts about their work. In this regard, the present study makes an important contribution to research in this area.

## Presentation of Findings

Five major themes emerged for the women therapists who took part in this study, related to issues they were currently working on or had resolved in their lives and in therapy or analysis. The five most consistent themes which emerged in the interview data reported by the therapists were: (1) The therapist's relationship with her mother, especially with respect to areas of separation-individuation and identity; (2) Fear of success, as manifested by the therapist's empathic identification with her patient's inhibitions, conflicts over ambition, and devaluation of self-worth; (3) Role conflicts, with respect to family and relationship needs versus career pursuits, and conflicts over feminine-masculine role stereotypes in professional roles; (4) Envy in the countertransference, as related either to dependency feelings, or to mourning; and (5) The life stage of the therapist.

This chapter presents a discussion of the findings presented in Chapter V with respect to these themes. It also discusses problems and limitations of the study, as well as its implications for clinical practice and further research.

Theme 1: The Therapist's Relationship with Her Mother

Separating and individuating the self is a dynamic process that continues throughout life. Similarly, the process of discovering one's identification as a woman builds cumulatively out of the ebb and flow of life, the moving away from, and returning in memory to, our mothers. This takes place, of course, not so much with the mother as the constant point of reference, but in the reconstruction and reworking in life, as well as in psychotherapy, of selective aspects of one's identifications. For many of the female psychotherapists in this study, the feelings and issues evoked in the treatment of their women patients impinged strongly on their own identification and on separation process.

In the interview with Therapist B, Mahler's (1963, 1964, 1968, 1970, 1975, 1981) writings on the crucial importance of the mother's availability during the rapprochement phase of the separation-individuation process is extremely relevant. It also is applicable to the interviews of Therapists C and Q. By "being there" as a stable and consistent source, all three of these therapists became, for their women patients, the constant object, encouraging a healthier separation.

As the patient persistently tested her and ventilated her aggression toward her, Therapist B tolerated

her patient's acting out, her negative transference. "I tolerated it, and accepted it," Therapist B said, "and nobody had ever accepted it from her before. I allowed her to ventilate, to explore, to act out her negative feelings by persistent cancellations, but I remained steadfast through it all and we both got to the other side."

Mahler's practicing subphase of separation-individuation is reflected in the perpetual testing, resistance, movements, and regressions a patient like the one Therapist B described has to experience in order to practice, hatch and eventually separate. But always, the patient, as B described, carefully tested whether the therapist would remain with her, and once assured, was ready to explore her world on her own.

As observed in the interview with B (and C and Q as well), a deep reconstruction takes place in the unique relationship between female therapist and her female patient. Within the transference and countertransference relationship, there are reawakenings for both patient and therapist of memories of their earliest relationship to their mothers.

Through the ambiance of the therapeutic relationship, certain aspects of female identification are integrated. Therapist B's most prominent issue was the repair and

reworking of aspects of her relationship to her mother through her work with her female patient.

The author and Therapist B shared their realization that every woman has to stand away and look at her mother. However, in order to separate from one's mother, one must first be close to her. It is presumed that virtually every woman has something to repair with her mother, and this is a lifelong process.

Each of the therapists in their relationships with their patients became the transferential person of significance, permitting a sensitive and dramatic reworking of the separation conflict, particularly as it related to the crisis of rapprochement and the Oedipal reactivation and resolution. The therapist provided an oppportunity to facilitate a healthier resolution of these issues for their women patients. However, as this study emphasizes, the women therapists themselves benefited from the reworking process.

The whole relationship of the woman to her mother is extremely complex. It seems to symbolize more than the relationship with the mother herself, but becomes the model for every relationship of intimacy and closeness. In all meaningful relationships, everything derives from the relationship with mother. In the therapeutic relationship with their female patients, Therapists B, C, and Q derived insights about their relationship to their own mothers.

The reactivation of such feelings for these therapists seem to indicate that many therapists find, unconsciously, in their work with certain patients, a way to become reacquainted with deeply submerged parts of themselves. B, for example, was startled when during the interview, she realized that the patient she presented resembled and shared similar characteristics with her mother.

Searles and Lang (1980) speak of the therapist's need to repair the mother as one aspect of what the therapist derives from the treatment process. Searles feels that ultimately everyone needs to return to their mothers. Further support for this view is echoed by Smith and Smith (1981) who reflect on the dimensions of the mother-daughter relationship, focusing on the necessity to revisit the relationship with one's mother, explore one's identity, and reexamine one's own roles.

Therapist B's countertransference feelings provided a dramatic illustration that every woman seeks to understand her relationship to her mother in her lifetime. Exploration of her patient's deprived early life put B in touch with aspects of her own life, particularly memories of unresolved feelings of loss to her long deceased mother.

Many therapists, like B, C and Q, gave to their women patients what they themselves had not received from their mothers. Therapist B said about her patient: "She had to work through, in the transference, while I held still . . . even though she had won an Oedipal victory!"

Therapists A, B, C, J, and T spoke in their interviews of having given their women patients a freedom from fear, and an experience which many of them had had in their own therapies or analyses. They saw themselves as consistent people who were "there" and "at home" while their patients explored and discovered new internal and external dimensions of themselves.

Smith and Smith (1981) state,

> For a therapist, the work of sorting out the mother-daughter relationship is never complete. The mother becomes old, or the daughter becomes a mother, and all of this will mean that the mother-daughter relationship will need revisiting, especially at times of passage. This is a continuing dialogue in the service of rapprochement. (p. 66)

In helping female patients to achieve a sense of their own identities and to merge in a self-realizing manner into the world, it is clear from this study that many of the female therapists had a maternal countertransference. It is equally clear that the therapists had gained awareness and knowledge of many of these issues with their female patients through their own analysis or psychotherapy.

Many of them continued to explore these inner feelings through analytic consultation. Their personal awareness of the nature of these countertransference feelings and their willingness to be alert and open to them, greatly promoted the successful treatment of their female patients.

These interviews might be said to reflect what "caring" is in the psychotherapeutic relationship. While this word is usually not used, because it may connote the more "feely-touchy" forms of therapy, caring is definitely present, as illustrated by the following statements:

> I wanted her to have what I never had . . . my mother could not have encouraged me to go to college. She would feel I would devalue her. But I wanted my patient to know that, not only should she get the best for herself . . . I wanted her to go beyond me.

> I cared for her and applauded her growth, . . . I had always wanted a daughter, and although I knew she wasn't my daughter, I could help facilitate her growth as my mother could not do.

However, the real caring, as the author defines it in the psychotherapeutic relationship, and as she saw it present with all of the therapists in this study, is presented in the form of a composite statement from Therapists B, C, and Q:

> I knew that I must be aware, or try to be of my own feelings for her . . . . If I hadn't been aware, then I could have derived too much gratification from being her model, and might have stood in the way of her achieving some

> identification with her mother . . . so, whatever I felt about her, she had to unfold in her own way, not mine . . . after all, what is the one thing we can provide that many of these women, including ourselves, never had--choices, an atmosphere for the discovery of one's own self and a safe place to explore, to practice, to hatch, and ultimately to separate.

Theme 2: Fear of Success

Fear of success manifests itself in the intracacies of practice in subtle and sometimes more overt ways. From the vantage point of clinical experience, fear of success is hard to define because it is irrevocably interwoven into the mainspring of women's conflicts, decisions, and choices (or the lack of them). Beneath the fear of success lies a link to the earliest relationship between women and their mothers. All subsequent conflicts related to roles for women, i.e., familial versus professional roles, autonomy versus dependency, and the stifling of ambition, assertiveness and creativity, emanate from that source. These origins combined with a restrictive sociocultural environment, lead, ultimately, to those fears which act as a barrier to success or to women achieving self-satisfaction.

The identification with their women patients can be seen clearly in the empathic and often frustrated feelings that the women psychotherapists in this study felt. They viewed themselves in the mirror of women patients

who were constricted, inhibited, and caught in internal dilemmas related to their roles as women and to their sense of emotional well-being and self-actualizing potentials. The interviews with M, T, and E illustrated those considerations.

Therapist M describes her patient as struggling with a particular conflict related to this fear of success: work inhibition. M's patient was a young, extremely intelligent physician. While able to complete scheduled work easily, she had trouble working independently. She submerged her intelligence when relating to her male colleagues. During the treatment, it became apparent that her socialite mother really would have preferred her daughter to be an Asian-American princess, an object of adoration, dependent, and passive. Therapist M identified with these feelings. She too had had a mother who gave her ambiguous messages.

Professionally, both the patient and the therapist had a hard time taking the initiative and being assertive. They also realized that they acted out the part of their mothers which they disliked the most: the helpless, confused, not-too-bright, disorganized, dependent little girl. Their major conflict was that they did not want to be beautiful, successful housewives and mothers, but neither were they able to "own" and "acknowledge" (author's terminology) their roles as successful

professional women, the role least valued by their mothers.

Horner (1965) concluded, in her landmark study on fear of success,

> There is mounting evidence . . . suggesting that many achievement-oriented American women, when faced with the conflict between their feminine image and developing their abilities and interests, disguise their ability and abdicate from competition in the outside world. When success is likely, or possible, threatened by the negative consequences they expect to follow success, young women become anxious and their positive achievement strivings become thwarted. In this way, their abilities, interests and intellectual potential remain inhibited and unfulfilled. (p. 171)

Freud (1916) first described fear of success as deriving from guilt reactions engendered during the Oedipal period, when forward movement is perceived as rivalrous and fraught with violence. Similarly, Applegarth (1977), in regard to other women analysts, reports that the conflict in women reflects guilt and fear at surpassing the mother.

Hoffman (1972, 1974) furthered the study by concluding that women feared success because they feared affiliative loss. Reviewing child developmental studies, she shed light on female achievement motives, suggesting that females have high needs for affiliation which influence their achievement motives and behavior, often blocking them. Girls, she believed, received less encouragement

than boys for independence, more parental protectiveness, less pressure for establishing an identity separate from the mother, and less encouragement toward independent exploration of their environments.

Hoffman's thesis is that girls are given inadequate parental encouragement in early independence strivings. Furthermore, the separation of the self from the mother is delayed or incomplete for the girl because she is the same sex with the same sex-role expectations. She feels that girls do not develop confidence in their ability to cope independently in the environment, and retain their infantile fears of abandonment. Safety and effectiveness lie in affectional ties.

While Horner and Hoffman opened important doors to the study of the inhibitions and fears of success of women, they also left open questions that required a more in-depth penetration into the internal world of women's intrapsychic fears and barriers, and the developmental origins of these constrictions and barriers.

Miller (1980) states,

> Culturally enhanced competitive strivings conflict with the expectation of retaliation and loss of love. This feeling is certainly anxiety producing and may be equated with parental anxiety communicated through emotionally laden approval and disapproval, the very conditions conducive to the development of security operations. If the mother, who is

> the primary caretaker, is idiosyncratically threatened by these feelings and then attempts to move towards success and autonomy, she communicates that anxiety to the child, as hypothesized in Sullivanian theory. The threat may be greater for mother-daughter than for any others because of the cultural definition of feminine development. At the Oedipal phase, therefore, not only is resolution as Freud hypothesized (1931, 1933) theoretically more difficult for girls than boys, the girls comes to it already more burdened by effects of maternal anxiety and of cultural sex-role norms as well. (p. 385)

Conflicts regarding the issue of ambition, achievement and assertiveness within the fear of success are illuminated by the interview with Therapist T. She described two of her patients as young, unhappy, and depressed. Both worked beneath their capabilities. They expressed the fear of "going beyond" their family and friends. They saw success as causing enmity and envy, inflicting pain, being destructive to relationships, devaluing those they wished to leave behind and, therefore, losing them.

Therapist T had also dealt with such similar feelings regarding her own mother and success. The issues for all three women were that "going beyond" to better jobs would be tantamount to going away from mother and feeling a devastating loss. Therapist T understood this and used her countertransference to assist, encourage, and be ever patient as the transitional support person for her patients in dealing with these fears. The question of

freeing women patients from their intrapsychic constrictions, from the inhibitions that serve to keep their ambitions in check, from the barriers to realizing and allowing their fantasies to materialize into realities, can be viewed in this interview. Moreover, working through the transference relationship with the women therapist helped to "free" her patients. While the therapist insisted that they "freed" themselves, the author contends that the therapist's sensitivity to the issues involved, her awareness of the separation-individuation struggle, her empathy towards their need for encouragement, constancy, patience, endurance and skill were instrumental to the success of the treatment.

Women therapists spoke in their interviews of giving their women patients a freedom from fear, and an experience which they had had in their own therapies or analysis, or had never had--a consistent, patient person who was "there" and "at home" while their patients explored and discovered new internal and external dimensions of themselves.

Therapist E's interview represents an example of inhibited creativity, another symptom of the fear of success. Her patient, a woman writer, shared a family background parallel to E's. It was an environment indifferent to creative endeavors. The indifference created a

stifling environment for these women. During the treatment, in "freeing up" her patient, the therapist became aware of her own wish to "free up" her own creative process.

Thus, as Therapist E shared the common experience of having a mother who could neither understand nor appreciate her daughter's creative pursuits, she could not only understand her patient's need to create, but wished to encourage it. An excellent opportunity was provided for both E and her patient to rework their creative identity within the resonance of the therapeutic relationship.

The patients described reflected the feeling that in succeeding or going too far, the gain would be a loss. Success in anything was predicted to mean the loss of a supportive, needed relationship. This is a crisis of "rapprochement." The desire to go beyond and move ahead is there, but there is anxiety that the significant relational other (originally the mother) will fail to remain constant, and "be there" as the encouraging, steadfast supporter. The interviews with T, M, and E reflect the difficulties patients had in truly acknowledging their potential and using it. In the transference, what is revealed are the barriers to forward movement for these women arising out of unresolved Oedipal conflict with their mothers and the outgrowth of faulty separation-individuation experiences.

Friedman (1980), emphasizing the fear of difference in the relationship between mothers and daughters, points to the unresolved hurt between mother and daughter around the feeling of loss, a dynamic directly relevant to Therapist T and her patient. The underlying fear, whether the manifestation is envy or hostility, is of devaluing the mother. The daughter fears that by moving forward and excelling, perhaps exceeding the mother, she is hurting the mother by devaluing her image, her values, and her investment.

Schecter (1979) describes patients who express fears of failing, as well as being the object of criticism, humiliation, and shame. They are unable to experience any joy or pleasure in success, other than transient highs. They become aware of self-defeating masochistic behavior such as sabotaging their success and, attendant upon their success, an incapacitating depression may set in. This presents the portrait of a person in mourning, and the message she communicates may be some version of the following: "Now that I have everything, what I always wanted, I have nothing."

The author has viewed in her clinical practice with women not only the motive to avoid success but, once having succeeded, the attempt to hide her success. Similarly, in the early Horner studies (1965, 1968, 1971),

successful female students preferred not to divulge the fact to male peers that they were doing well, preferring instead to make their failures known. Many young women reported changes in future career plans toward what they considered to be more traditional, appropriately "feminine," less ambitious careers. Thus, to be less ambitious, less aspiring, and to enter occupations reflecting a more "feminine" direction was experienced as less anxiety-producing.

Therapist F experienced similar feelings during a therapeutic encounter with a brilliant woman patient, a composer of music, who diminished and wanted to hide her beautiful works. The therapist said, "When I started moving up in the profession I wanted to hide myself. I felt almost ashamed, like I couldn't possibly be good enough. I felt fraudulent." This was related to the therapist's mother's subtle message that "you're getting too big for your britches." In reality the message was all too clear: "Don't surpass me or you will lose me."

Person (1982) observes that the sense of fraudulence and fear of exposure as a fraud are prevalent in women's self-evaluations at all levels of achievement. While all too often this is interpreted in terms of a castration complex and penis envy, the underlying conflict is related to the fear of deviance, that being feminine is culturally defined, and the requirements of competence

are in conflict. The successful professional woman protects her "femininity" by denying the authenticity of her ambition behind an ingratiating mask; she often practices a real deceit. The sense of fraudulence is displaced from an imposture about intent to a subjective sense of inadequacy.

Aspiring, and owning their aspirations, caused profound guilt and anxiety for many of the women. The origin of this was the fear of surpassing their mothers. As seen frequently in practice, the "rapprochement" conflicts manifests itself in the feeling: "If you go too far away, then try to come back, mother is not going to be available to you. So you better not go too far away." This also refers to going too far beyond the mother which also leads to (fear of) loss.

Women have not progressed as far as many contend. Indeed, while some of the gains made for women since Horner's landmark study in 1965 have been noteworthy, in other areas there are vast discrepancies and the progress for women is questionable. The question is, are the barriers solely external, and imposed by the society? Or, do women themselves militate against their deepest ambitions, needs and productive desires?

This study shows that women patients, their women therapists, and perhaps women in general, fear success

or at least question themselves and fail to see it when they achieve it. The author notes how many of the women psychotherapists in this study negated, devalued, or diminished their obviously skillful and creative therapeutic work.

Friedman (1980) links fear of success to difficulties in separation and individuation, reflecting upon patients who manifest classical Oedipal wishes and guilt and begin to reflect, in dreams, fears of success. Themes emerge, involving feelings of being isolated and alone, being bad if they succeed, viewing the achivement of selfhood a disloyal act. The patient may have dreams in which the therapist betrays her, rejects and disapproves of her. This leads to awareness of her fear that the therapist (mother) would not want to share her capabilities as a woman. She feels convinced that if she is different, holds unique ideas, she will give up the link and, thus, be cut off from her family and therapist.

Fear of success in women, in the author's view, is related to intrapsychic conflicts derived from unresolved Oedipal struggles and faulty resolution of separation-individuation issues. Superimposed are the ever-present cultural restrictions imposed on women, and women's fear of deviance from the prescribed and still prevalent codes for "masculine" and "feminine" behavior imposed by society.

Intellectual functioning is perceived by many, if not all, women as phallic and, therefore, masculine. Thus, many women will shun intellectual or creative pursuits, or hide their accomplishments in this area.

Galenson (1977) believes that the examination performance-anxiety in women whom she has treated is dynamically and genetically different from the same symptoms in men. This difference has considerable significance in regard to the more general fear of competition and self-esteem regulation in women. The difference stems from the divergent lines of development in the two sexes, beginning in the latter part of the second year of life. Galenson believes that during this early genital phase, attributes and qualities connected with maleness and femaleness begin to be slowly integrated by the child. In the view of Galenson and Roiphe, the primary cathexis of the genitals and the genital anatomical difference affects other sectors of developmental object relations, drive organization, and many aspects of ego functioning.

This dilemma also manifests itself in the fear of success which females experience when the option of choosing a career conflicts with heterosexual attachments. Intellectual competition with men must be reconciled with a feminine role in the love relationship by those women who wish to pursue a professional career. The fears of

women who are anxious that their career aspirations, intelligence or skills will threaten their love relationships with men are not merely fantasies. They are, in many cases, quite real. The culture has not kept pace with the desires and ambitions that women are freeing in themselves. Consequently, the frustrations of women are even greater than when the stereotyped role constrictions were much more in force. Many of the young women patients seen today complain that choices are becoming more polarized. "If a woman wants to succeed," one young patient in her thirties said to me, "she has to be prepared to give up a lot. We wind up career-bound, but alone. Men are simply uncomfortable at the least, threatened at the most, and where does that leave us?"

Theme 3: Role Conflicts

Conflicts which women possess related to the still-prevailing traditional codes for feminine and masculine behavior are of an intrapsychic nature, but are tenaciously reinforced by the culture as well. A significant conflict for many of the therapists concerned the balancing of familial and professional roles. Both themes arose for female therapists O, S, P and J and for their patients.

Therapist S's patient wished for both a successful profession and an intimate relationship. She felt the need for a therapist/analyst who could also be a role

model in this area. Therapist S noted her patient felt forced to choose between career advancement and her intimate relationship, because professional advancement required that she move away from the city where her lover lived. She felt that such a move would mean an even greater loss of an important relationship.

S's patient looked to her therapist as a role model and mentor in helping to solve this dilemma. Although the author is not defining mentor in the strictest sense of the word, in this study, therapists frequently described their patients' mentor-like relationship. In this context, mentor is defined as a female champion who has empathy for her patient's wish to facilitate a balance between her relational pursuits and her aggressive, intellectual strivings.

Douvan (1976) states that her experience has led her to conclude that many women need and use older models, however specifically, for their own purposes and growth . . . knowing women who have integrated achievement into gratifying lives must ease some of the anxieties that so commonly accompany and inhibit success in women.

The inculcation of the culture's adherence to strict codes of masculine and feminine behavior can be seen in the way women view such strivings as ambition, assertiveness, and achievement. It is startling to consider that, in

supposedly such a progressive age, women have such negative feelings about being ambitious, or being called ambitious.

Epstein (1980) feels that ambition in America is seen more in the sense of "Blind Ambition," and is attached to negative connotations such as "carnal," and "greedy." The word ambition is seen as anathema to many women, and as one therapist said, "You use the word ambitious with a woman patient and they think of themselves as wanting to be a man--they see it as masculine." This notion was confirmed by the author's mini-survey of a woman's group comprised of accomplished, high-level professional women, all of whom felt criticized and blanched at being called "ambitious." Self-awareness of their own conflicts around aggression and ambition led the therapists to aid their patients in reconciling such role conflicts.

The latitude therapists gave to their patients to examine their conflicts and evolve towards their own choices was related to several of the therapists' dynamics. Therapists O, S and N had mothers who were professional career women and who abhorred being "traditional" women. They insisted their daughters pursue a career. Through the ambiance of the therapeutic process, these therapists gave a considerable amount of space to their female patients in order to encourage their evolution in their own way and in their own time.

Many therapists were aware of difficulty with the "overly-feminine-super-sweet" woman. While they realized that this was a defensive mechanism on the part of their patients, they felt that their patients' manner tapped too closely into an area within them (self-effacing, timid, shy, coy) which they had fought to overcome.

Horney (1926-1935) decried the confusion about the early definitions of femininity, contesting Freud's allusion to the woman as an "homme manque." Femininity was innate and present at birth, she contended. She viewed woman as having a complex web of conflicting feelings and needs, and caught between her compulsive efforts to be compliant, lovable, and self-effacing and her healthy need for growth and self-expression. Horney described conflicts and symptoms that she called "neurotic dependency," which have been idealized by our culture as "femininity."

Deutsch (1944), a classical psychoanalyst, describes "healthy women" in terms that now sound incredibly dated--almost Victorian--although only 40 years have passed. Such women, she said, are:

> The ideal life-companion . . . ideal collaborators who inspire their men and are themselves happiest in this role . . . the loveliest and most unaggressive of helpmates . . . they want to remain in that role. They do not insist on their rights, quite the contrary. They are easy to handle in every way if one only loves them . . . They are willing to renounce their achievements, without feeling that they are

> sacrificing anything, and they rejoice in the achievements of their companions . . . they have an extraordinary need of support when engaged in any activity directed outward. (pp. 290-291)

Symonds (1976) says,

> Young girls are given these values and expectations by parents, teachers, society, and finally by the entire culture. To live up to them takes tremendous effort; to be able to renounce their achievements without feeling they are sacrificing requires a heroism that borders on lunacy. To live up to these ideals takes tremendous effort . . . therefore, they often repress their initiative, give up their ambitions and aspirations and unfortunately end up at times excessively dependent with a deep sense of insecurity and uncertainty about their own abilities and their own worth. (p. 112)

Horney and Symond's comments provide an interesting argument as to why Therapist I spends 75 to 80 percent of her time working with female patients to overcome their fears related to ambition and aggression. I noted the strong feelings she had in viewing the coping strategy of her patient, a "saccharine sweet" personality--"the only answer she had to surviving in the world she came from," said the therapist. I quickly noted her counter-transference, in wanting to encourage her patient's assertiveness too quickly--a feeling connected I with her own past. The therapist said:

> Her having so little ambition was a big mystery to me. Somehow in this brilliant woman who could have been anything she wanted, she wanted too little for herself . . . somehow her ambition

> got stopped . . . she talks about wanting her life to change, but she does not aspire! . . . Where is her ambition?

The therapist, aware of the strong feelings this patient evoked in her, also recognized that her patient had to unfold in her own time, and in her own way, and that the therapist had to control her urges to "egg the patient on."

The conflicts females have about their role as women can be reflected in the confusions and contrasting views related to the definition of femininity. The literature review contains the considerable contributions of Freud, Horney, and Stoller to the subject of female development and gender identity. The missing link in Freud's theories on female psychosexual development was gender identity. The study of gender identity has caused a major correction of Freud's theory about early female sexuality (Galenson & Roiphe, 1968, 1974, 1977; Greenson, 1956; Kleeman, 1971; Stoller, 1964, 1968).

Stoller (1963) said, "From observing little girls they show definitive signs of femininity long before the phallic and Oedipal phases and one can trace back early femininity from at least the first year or so of life." The significance of Stoller's contribution to female development is that women are said to have an original and innate femininity, and are not derived from the male. In fact,

in his views on protofemininity, Stoller (1968) maintains that the origin of all genders is feminine, and Greenson (1956), in his concept on "disidentity," agreed and felt that boys have a harder time separating since they must "disidentify" from their mothers, while girls retain this identity.

Therapists G, O, and P questioned whether a woman can have a full career, a rich and fruitful familial relationship, and a social life in a society where women still take on greater responsibility for children and the family relationships. Many women therapists felt it is not possible for women to do justice to both career and family, as the role structures in this society are still prevalently opposed to careers for women. It is clear that, as professional women, they have to struggle with considerably more conflict of this kind than men do. Women therapists have to struggle not only with psychological conflicts, but with sociocultural and familial pressures as well.

Role conflicts in balancing familial and professional roles were reflected by Therapists T and A who both had two children under 12. They spoke of their conflictual feelings of guilt in balancing their mothering roles and their family roles with their roles as professional women. One of them stated: "I feel guilty if the balance gets tipped; if I am away from home or too involved in my work

I get confused--am I going to be away from them (her children) as my mother was from me." Therapist A said, "At times I feel like I'm not being a good mother, to my children, or to my patients."

The therapists felt that as professional women, because of the traditional role expectations foisted upon them, they really had to struggle with considerably more conflict than men do, or perhaps conflicts of a unique kind: to strike a balance between their mothering and their professional roles.

In reflecting upon their own cultural imperatives, Therapists S, R and P acknowledged the priority of marriage and children. The family role was most valued. Intelligence and their potentials in areas of achievement were ignored or overlooked by their parents. Therapists who experienced a mourning and reevaluative process, brought on by their work with their patients, often regretted that in their earlier lives they had not had the choices that their younger patients had. Further, they felt sadness that they had had no one who would encourage them as they had encouraged their female patients.

Interestingly, despite their remorse at not being encouraged more in intellectual or achievement pursuits, the majority of therapists in the study placed an enormous value on their women patients achieving intimacy and

having a relationship. Intimacy and relationship were, without question, almost every therapist's view of what their patients needed to attain in order for the therapists to consider the treatment a success. Several said they would feel like failures, no matter how much they had "freed" their women patients to be self-realizing, achieving, and productive in their professional or other work, if the patients did not have relationships. This was interesting in light of the therapists' earlier expressed wishes to have been encouraged in more assertive pursuits.

Perhaps the key to this mystery is the role of choice. Therapists spoke of their mothers as having very few options other than their dissatisfying traditional roles as women. This same concept of female role was transmitted to them in the early cultural and familial relationship between mother and daughter. Later in their teens, they regretted that they had not been encouraged to explore other options. This led many of the therapists to experience both feelings of envy and admiration toward their younger patients who were living in a cultural context more supportive of options for women--but also to be keenly aware of the intrapsychic conflicts which precluded their patients realizing them.

Theme 4: Envy in the Countertransference

Considerations essential to any discussion of envy in the countertransference are first, an acceptance that it is often present, and, second, a realization that, like countertransference, it is not necessarily negative but, it does require attention on the part of the therapist. Clearly, envy must be understood if it is to be put to constructive use on behalf of the patient. The greatest protection against acting out one's envy is the therapist's awareness and understanding of it.

Therapist A questioned, "Can you successfully treat a patient you envy without awareness of that envy?" The author replied, "You can certainly treat her, but not successfully!"

Both Searles (1968) and Winnicott (1949) speak of the need for the therapist to be aware of his or her envy, and further commented on the difficulty in recognizing it. Countertransference envy within this study of female therapists was traced to the therapists' unrequited dependency needs which were reactivated within the treatment situation with female patients. These occurred prominently with women patients who were indulged by spouses or had been enabled to remain dependent. Envy further led to mourning among many of the therapists, who were all too aware of

their patients' youth and opportunities, and who reflected upon their own lost opportunities.

Examination of their feelings of envy enabled the female therapists to gain insights about their patients' needs and their own needs as well. Because of their own inestimably important experiences as patients in analytic psychotherapy, the therapists were able to confront and manage their envy, get to the other side of it, and experience admiration and sometimes awe of their patients. One could imagine a very different outcome if therapists had not been able to work with their own countertransference.

Many of the therapists commented on the enormous importance their analyses, or ongoing consultation, had in being aware of their countertransference feelings. Therapist R spoke of the importance of being aware of the defensive function of the maternal countertransference:

> It was crucial to effective treatment. I would not be able to make proper interventions around her conflicts because I would not see them as conflicts. I would not see them as problems for her, so I could not be effective at all unless I had that aspect of myself analyzed. As I continue to resolve these areas, my envy or my feelings about my patient reduce. I am very aware of them, and am clear that my role as a facilitator is not a defensive one. The more I clear up for myself, the more I become more comfortable with her, and see her more as she really is with her own conflicts.

R commented on the value of her experience as a patient: "I would not get caught up in a kind of countertransference

involvement--I freed myself from that considerably by looking at these conflicts within myself."

Envy begins at the mother's breast. Life is given by our mothers. They are the originators of the being called "us," and they possess all of the good supplies. Whether one loves them, or hates them, likes them or dislikes them, they are the givers of life, and enormously influential to the first portion of the child's development. Out of this recognition of their inestimable source of power, the child comes to envy them. They have what the child does not. They are the givers, and the child depends upon them for sustenance. Later in development, envy takes a rivalrous turn as the child envies mother's relationship with the father.

Klein (1924) maintains that adults seek to repair this deficit making reparations later in life for those early feelings of envy. Perhaps this is why Searles (1968) reflects that any working through of envy takes us back to our mothers.

Klein further states that we repair our envy by giving. Our own success, if it contributes to the world, or to people, productively and constructively, creates the experience of repair. In the author's view, repair is the reworking through self-analytic insight of a relationship, a theme, an issue in the therapist's life.

Repair is a mutually enhancing process, and can occur both for the psychotherapist and the patient.

Allphin (1981) talks of envy in the countertransference, and envy in social workers. "When people envy those above them in a social hierarchy, they may, in order to compensate, subtly encourage the envy of those beneath them in the hierarchy."

Women patients are frequently afraid of engendering envy in their therapists. Thus, diminishing or devaluing themselves within the transference is often to ward off "the evil eye," their fear of mother's anger and the subsequent loss of her. However, this is not limited to women patients, but to women in general. Men focus more on competition with other men; certainly they envy what their male peers may have. Women, however, seem to be much more concerned about the envy of other women.

Envy is much more dangerous when it is unconscious. It arises out of feelings of self-devaluation. Once it can be seen that the achievement of the other, or the acquisitions of the other, do not take away from oneself, then envy can become secondary, replaced by appropriate admiration and awe.

The subjugation of one's talents and the inhibitions of one's expression of creativity may also be tied to the fear that, once expressed, others will be envious. One may fear that envy will lead to loss or disfavor with the

other. The "sweet young thing" that Therapist O described may not have wanted her male lover to be envious of her obvious intelligence and accomplishments. The self-effacing professional may be warding off the imagined ill-will of her colleagues by hiding her accomplishments.

Envy has its productive and constructive usage. If resolved, it leads to admiration and awe. Also, envy leads to the process of mourning, a natural, second step in which the therapist reevaluates and rediscovers her feelings about the past, the present and, perhaps, her sense of direction for the future. Envy has to do with one's place in life. Each stage of life may produce new developments which bring satisfaction and an increasing sense of self-valuation, reducing the envy one has felt towards the accomplishments of others.

Theme 5: Life Stages

The therapist's stage of life will exercise considerable influence upon her attitudes, ideas and feelings both personally and in the treatment situation. As her goals and aspirations vary and change, so also may her approaches and techniques as she practices psychotherapy or psychoanalysis. Ego-ideals change, particularly at certain stages in life. In these interviews, the impact of the mid-life stage was very forceful. Discussion often centered on the patient's age, and then on the therapist's reflective

evaluation of her changing personal values, feelings and needs, as well as changes in her therapeutic work and thinking.

The therapists reflected upon the ages of their woman patients and their own phase of life as extremely important in determining the therapists' feelings about the case, their investment in the case, and similarly, the prognosis of the treatment. Therapist C made particular reference to several patients who were in their forties and fifties, living alone and without supportive relationships. This discussion opened the door to the therapist's reflecting upon her own feelings about her life stage.

Therapist J gave an excellent example of the enormous influence the therapist's life stage plays in her treatment of her woman patient. She related to her own changing feelings over a 10 year span and the influence they had on the patient's treatment.

Dimidjian (1982) described developmental issues for six female psychotherapists in their thirties. They attempted to maintain life-structures incorporating professional and personal commitments. She highlighted the complex concerns facing women in the profession of psychotherapy during their thirties. Despite the fact that the women therapists in this study's sample ranged from late thirties to late fifties, they, like the therapists in

Dimidjian's study, suffered from the predictable ambiguities and confusions attendant to women's roles in this society. Moreover, they struggled with the need to balance professional accomplishments with relational commitments. For the women in the current study relationships and intimacy became increasingly important in the mid-life cycle.

The mental health professions have changed markedly over the years. New approaches, theoretical considerations, and views of men and women have consistently altered many of the more traditional adherences in the field of psychotherapy and psychoanalysis. It stands to reason that a psychotherapist's approach to treatment would incorporate these newer contributions to knowledge. One example of this is cited by Therapist G who spoke of the considerable changes in her outlook toward female homosexuality since her entry into the mental health field 20 years ago. At that time, she viewed homosexuality as deviant behavior. Today, her viewpoints have changed along with those of many of the theorists and practitioners in the mental health field.

Other therapists, relating to the position women occupy in the current sociocultural milieu, felt that while women have gained considerable independence in the last decade, they are ending up poor and lonely. Middle-aged women, in particular, struggle to maintain balanced lives and become more fearful than their younger counterparts of making

significant changes. These ambiguities and conflicts were confirmed by Therapists J and G who verbalized their doubts and uncertainties about their life directions as they struggled with mid-life issues. They spoke of the difficulties for the single, divorced, middle-aged woman in a society which lionizes youth, and where a stigma is placed on women who are single, divorced, middle-aged, and alone.

Levinson's (1978) focus on the concept of the life-structure, in his study on the life stages of men in this society, and the impact of sociocultural, intrapsychic, and interpersonal aspects of their lives, is apt for the current study. In his theory, he reflects the concept of the life-structure, an individual's unique patterns of living in the world with others, which include aspects of the sociocultural world, intrapsychic world, and transactions between self and world. Levinson (1981) also speaks of the consequences for women who in their thirties choose career over relationship, and in their forties and fifties often deal with loneliness and alienation.

Therapists I, J, and P felt that the culture had not caught up with the gains that women have made. One therapist scoffed at a local political figure who enjoined industry to employ more women and minorities. She said: "Well, hell, we've been around that one years ago, and women are still not making the equivalent salaries of their male

counterparts." Another Therapist, A, saw the backlash against the women's movement as a manifestation, in a loud way, of the enjoinder, "You'd better stay married and stay protected, because you do not want to be poor and alone out there, and who the hell wants to be!" Therapists J and G stated that they had the same sentiments.

The global impression the author retained from these interviews in the overview, and particularly from those of P and J, were that the therapists made honest efforts to trace the changes in their life styles and values over the years. The author and the therapists wondered together if therapists, as they go through transitions in their own lives, are able to fully understand the changes within themselves and the possible impact of these changes upon the therapy with their patients.

In the interview with C, she was aware of grieving for the losses in her life through the intensive work with her patient. In the mid-life reevaluation and mourning process, she realized that she could help another to have those things which she could never have again. Likewise, Therapists P and R had significant insights into their phase of life, and reflected upon their past in their work with their younger women patients.

The life stage of the therapist will influence how she views herself, her world, and within the psychotherapeutic

milieu, her patient. As shown in the interviews with P and J, the study reflects that these therapists' attentiveness to their countertransference, and, in addition, to the impact their stage of life had upon them contributed to facilitating their patients' growth as well as their own.

## Summary and Conclusions

This study has attempted to discern and describe the major conscious inner feelings, thoughts, and attitudes of women therapists in their work with women patients. These inner experiences are referred to as countertransference. For purposes of this study, countertransference has been broadly defined as the bringing into play, especially but not exclusively in the therapeutic session, any portion of the totality of the therapist's attributes, experiences, and attitudes, through the stimulus of the resonating relationship with the patient. Countertransference refers to the feelings, attitudes, and opinions of the total person, and reflects the therapist's stage of life, her age, the givens of her life experiences, and all of the dynamics which comprise her total self, whether conscious or unconscious. The therapist's countertransference, then, is that which she feels toward the patient and within herself, and is a product of the therapist as a total person.

The five major themes, The Therapist's Relationship with her Mother; Fear of Success; Role Conflicts; Envy in the Countertransference; and Life Stages, have been discussed in detail in the preceding sections. It has become apparent that, while somewhat separable for purposes of this analysis, the five major themes are interlocking and ultimately related to early maternal experiences of both therapist and patient. It is concurrently clear, however, that both women psychotherapists and their patients are caught in a web of sociocultural stereotypes and role relations which pose major therapeutic challenges.

The focus of this research has been an elaboration of the intrapsychic conflicts of women, as viewed through the countertransference experiences of their female therapists. The author has presumed that these intrapsychic fears and conflicts prevent women from acknowledging and experiencing gratification in their own creative and intellectual pursuits. This, in turn, reinforces the impact of a sociocultural environment which continues to devalue women and to undermine their efforts to achieve legitimate recognition and equality.

In addition to the specific content of the five major countertransference themes described above, there are several general conclusions which can be drawn from these interviews. First, and perhaps most striking, is the extent to which women psychotherapists experience profound

resonance with their women patients. One may speculate that this resonance goes beyond simple empathy, and that it comes from a commonality of life experience and feelings through which women feel a strong and potentially healing bond with one another. The extent to which women seek other women as psychotherapists, as well as professional and personal role models, suggests that they are increasingly drawn to the potential of what one woman can offer another.

Second, the study seems to offer powerful evidence of the way in which the psychotherapist's countertransference, if left unacknowledged and unmanaged, can lend a potentially destructive valence to the treatment. Specifically, between women psychotherapists and their patients lies a realm of mutually unresolved conflicts which, if not properly handled by the psychotherapist, can mirror oppressive sociocultural attitudes and hence, be countertherapeutic. Conversely, it seems to be the case among the women therapists interviewed here that many of the countertransference issues which evolved in their treatment of women offered the potential for growth and reparative experiences to patient and therapist alike. Thus, countertransference became not only a reflective vehicle through which the patient's conflicts could be articulated and worked through, but also served as an impetus for the psychotherapist to struggle and resolve conflictual material of her own.

This is not to suggest, however, that mutually reparative experiences are automatically possible in the interplay of transference and countertransference materials. We can speculate that a major barrier to the resolution of certain conflicts among the five themes is that they are not yet subject to resolution within the culture at large. For example, it is not only that women are fearful of being forced to choose between achievement and intimate relationships, but that their fears are all too often confirmed by reality. While the etiology of the fear may be in the maternal-infant relationship, its current precipitant may be an all too real choice between career needs and family priorities. Similarly, the ongoing tensions between masculine and feminine roles exist not only in the psyche but in external social role relations. At best, the reparation possible in these conflicts may be a shared recognition that a healthy resolution does not yet exist in the culture at large.

One finding in the study which bears some reiteration was that 18 of the 20 women psychotherapists interviewed undervalued their obviously excellent therapeutic work. The author's impression of them as sensitive, aware, empathic, and highly skilled practitioners was either underplayed in the interviews, or for some, was not a view they shared about themselves. The practitioners did not

notice this attitude in themselves, nor did they link it to the five countertransference themes described in preceding sections. Although one could speculate that this might be an attitude shared by most psychotherapists, irrespective of gender, the profession as a whole is probably not notable for such humility. Rather, the author sees this self-devaluation as a theme which cuts across all five of the countertransference themes and which exists as a profound undercurrent to most of the patient's feelings described by the women psychotherapists. Although it is not exclusively women who undervalue or distrust their achievements, there may be a strong gender component at work, just as there appears to be a gender component in the five countertransference themes.

More precise validation of a gender component in the countertransference themes can only occur at such time as another researcher undertakes a four-celled analysis of countertransference to male and female patients among male and female therapists. It was neither within the scope nor intention of this study to undertake such a broad analysis. Nevertheless, a question posed herein was whether any or all countertransference issues to be identified in the study could be said to have a gender component.

Despite the absence of a male sample, this author would argue for an affirmative answer to the question. There is

no question that male psychotherapists must work with countertransference issues having to do with their early maternal relationship, fear of success, role conflicts, envy, and life stages. Still, the content of these issues can be seen as very different for men and women. Masculinity, male development, and male achievement, have all been taken as an implicit standard against which, in theoretical formulations as well as in reality, women have been measured and found wanting. An example may serve to illustrate: a single man of age 50 may be perceived as the "bon vivant," while a single woman of 50 is thought of as an "aging spinster." Thus, the cultural impact of life stage, as a countertransference theme, may be radically different for men and women.

Relationship to mother, similarly, poses a range of developmental challenges to men and women, having to do with separation/individuation, the resolution of the Oedipus, and the development of gender identity. Intrapsychic tasks are coupled with a cultural preference for male children, and a concurrent implicit devaluing of female children. Thus, the gender component of this theme is the aspect of it which goes beyond the obvious differences male and female children experience in relationship to their mothers.

Fear of success, too, may be gender-linked in the content of countertransference issues which it poses. While

men may need to grapple with the nature of their relationship to work and career, it is taken for granted by the culture that their working lives will in no way preclude access to familial ties or intimate relationships. Women, as the author has discussed previously, seem forced to choose between the two, either in fantasy, in reality, or both.

Role conflicts are becoming an increasingly profound issue for both men and women, as role options expand and as the definitions of "masculine" and "feminine" yield to a culturally expanded awareness of androgeny. This is not to say that male and female role stereotypes no longer operate, however. In general, one may say that feminine role stereotypes still contain more implied pejoratives, while masculine roles are seen as positive and desirable. Thus, while men may choose to risk taking on role behaviors which have been previously labeled "feminine"--tenderness, gentleness, nurturance, or caretaking, for example--women are still discouraged from adopting what have been characteristically masculine behaviors: aggression, ambition, competition, and achievement.

Finally, the gender component of envy in the countertransference is less clear, and may not exist to the extent that it does in the other four themes. The author can speculate that envy based on self-devaluation may be an

experience more familiar to women, and thus they may appear to be more prone to envy than men. Nevertheless, considerable further exploration of the issue would be needed before a gender component could be posited.

In conclusion, arising out of this study, which is a blend of psychoanalytic and sociocultural considerations related to the countertransference themes affecting women psychotherapists in their treatment of women patients, is an important image. As a result of the prudent and concerned awareness of their countertransference themes, the women therapists in the study displayed immeasurable respect for their women patients. By allowing their patients the widest latitude to make their own choices and unfold in their own way, the therapists displayed what is, at all times, the height of caring in the psychotherapeutic relationship: the respect one has for another as a self-determining individual whose power is in making one's own choices, without intrusion or imposition of others.

## Discussion of the Problems and Limitations

Numerous problems and limitations were encountered in the process of implementing this research study. One problem was the richness and abundance of the data deriving from the interviews with the therapists. The interviews yielded such interesting and illuminating material that

it was hard to select what was most meaningful for the study.

The length of the interview may have been responsible for this mixed blessing. On the one hand, interviews were lengthy and, thus, yielded too much data. On the other hand, some of the therapists did not think the interviews were long enough and requested that they continue beyond the scheduled time.

The effect that these problems had on the analysis and interpretation of the data was the sacrifice of depth for breadth.

The sheer amount of data also contributed to another difficulty which undoubtedly influenced the study's evolution. The reader will note that, in certain sections of the Findings and Discussion of Findings, there is considerable repetition and overlapping of themes. Had the study sample been smaller, this could have been avoided. The researcher strongly suggests that in research studies which utilize in-depth interviewing with human subjects, the sample be kept small, so depth can replace breadth.

The repetitions were unavoidable, however, because due to the interdependent and overlapping nature of the themes, deletion of repetition in any section would have diluted the meaning and the impact of the therapist's statement.

Within the person-to-person-encounter of the research interviews consideration must be given to the transference feelings of the interviewee-therapist to the researcher, and the countertransference feelings of the researcher-therapist to her interviewee-colleagues. This may have posed a limitation on the study in terms of the therapists' feelings of exposure to a professional colleague. The researcher countertransference may also have been operative in making inferences about "unconscious" material supplied by the interviewees.

Last, the sample was not randomly selected. Psychotherapist--subjects were required to have spent a period of time in psychoanalysis or psychoanalytic therapy, and to employ a psychoanalytic orientation in their own practices. No control groups were used for comparison. As has been noted in the Introductory Section on Limitations, women therapists selected for this study were from the same socio-economic class. Therefore, only by inference can the results be generalized to the wider population of female psychotherapists.

## Practical Implications

### Implications for Clinical Practice

A number of this study's findings have implications for the clinical practice of women psychotherapists in

particular, and for psychotherapists in general. The author felt strongly that, in order to study the thoughts and feelings of psychotherapists, it would be important to use a methodology which included direct, in-depth contact between researcher and subjects.

Five implications for practitioners deriving from the findings of this study involve considerations for clinical practice. These include (1) countertransference; (2) the importance of psychoanalysis or analytic-psychotherapy; (3) consultation and supervision; (4) the therapeutic ego-ideal; and (5) gender considerations in the choice of a psychotherapist.

The female therapists who took part in this study were all in, or had been in, psychoanalysis or psychoanalytic-psychotherapy. This enabled them, in their treatment of their female patients, to be aware of their own countertransference. This does not suggest that there is certitude about a psychotherapist's awareness of her countertransference at all times. And further, simply because a practitioner has had analysis or psychotherapy is no guarantee that countertransference awareness or management will be present. However, what the female therapists of this study reflected, and what the author contends demonstrated real psychotherapeutic "caring," was their concern and attentiveness to

their countertransference and their wish to know about their inner feelings as much as it was possible to know.

Psychoanalysis or psychoanalytic-psychotherapy should be a prerequisite for all therapists who engage in intensive psychotherapeutic treatment. In the author's view, one should not engage in any form of in-depth psychotherapy without having had a similar experience as a patient. Concomitantly, ongoing consultation should be required for all psychotherapists regardless of their years of experience or amount of therapy, either in the form of individual or peer-group consultation or supervision.

One therapist in the study said: "It should be against some ethical law for anybody to do intensive treatment who has not had it. If you have been through it yourself you know the tenacity with which people hold onto the old patterns . . . and the treatment won't be aborted prematurely."

In addition to these considerations, the consistency provided by the female therapists in the study suggests that they brought a therapeutic optimism to their work with their female patients, unwavering in their confidence that the therapeutic process works, based on the therapists' own experience from their own therapy or analysis. There was an enthusiasm, a belief in the process, and as one therapist said, "I'm giving to my patient what my analyst gave to me:

patience, endurance and a steady belief that together we would get to the other side. So with my patient, I'll hang in no matter how long it takes, because it will work, and I know it can work."

For psychotherapists in general, the enormous importance of knowing themselves, and being able to sort out and separate the multitude of often intense feelings which arise in the two-person psychotherapy situation, cannot be overemphasized. For women psychotherapists in particular, the study suggests that there are women's issues which reactivate memories and produce intense emotions. These issues must be prudently considered by therapists in their work with their women patients. The author has noted in another section of this study that the requested spontaneous selection of the patient-subject by the therapist-interviewer was deliberate and based on her premise that women therapists identify more closely with certain patients. Many of the female therapists in the study chose to present women who were professional, and who were struggling with issues and problems similar to the ones they were struggling with or had resolved for themselves. It is apparent that there is a definite parallel process, one in which the therapist identifies with a person close to her own issues and reworks or adds to her own work on this issue in the psychotherapeutic process. The author's contention is that this is

not gender-related to the extent that all therapists learn from their patients, and that male therapists too, grow through their work with male patients on such issues as identification and separation-individuation. What is gender-related are the themes that emerge for all women (patients and therapists) and the need to be attentive to the strong and intense inner reactions women therapists feel within this process.

Attitudes about countertransference are still prevailingly negative in the therapeutic culture. Over many years as a consultant and supervisor for mental health professionals of all disciplines, the author became aware of how often therapists devalue themselves and their work when they were confronted with their countertransferences to their patients. Further, therapists devalue themselves for their doubts and uncertainties, and experience conflicts when they are faced with all kinds of questions related to their therapeutic work.

Thus, despite changes in the conceptualization and attitudes towards countertransference over the last decade, (i.e., it is no longer considered "original sin"), and the plethora of articles about more creative and productive uses of countertransference, it is still viewed with a considerable amount of negativity and shame by many psychotherapists.

Consideration of the therapist's countertransference as an exciting learning experience, or a route to profound discovery for therapist as well as patient, is often by-passed by the therapists who criticize this process in themselves.

In addition to the importance for the patient of understanding and being aware of countertransference feelings, there is a further benefit to the awareness. The therapist's awareness through her countertransference explorations may be utilized to produce important growth experience for herself. Furthermore, the use of countertransference exploration within the psychotherapy situation contributes to a more productive and creative approach to the patient.

Implications for women therapists arise from a surprising finding of this study. Women therapists tend to undervalue their work and to be highly self-critical of gaps in their therapeutic knowledge. Since this study dealt solely with female therapists, it is not known whether male therapists are as self-critical or unappreciative of their own obvious skills as were the therapists in the study. Women psychotherapists seemed to be dealing with a therapeutic ego-ideal; i.e., an idealized image of what should have been. Indeed, the author found that in all therapists interviewed, they were extremely sensitive, aware of their own feelings and able to separate them, empathic, and, in

the main, effective with their woman patients. One might say that by all judgments, the therapies were successful. Yet, the therapists' self-appraisals, in all but two of the interviews, were harsh. Several therapists were critical of their own conflicts. One in particular felt that she should have her own life totally together in order to help her woman patients. The therapists were making judgments about themselves which seemed to relate to their very high self-expectations.

One of Kohut's (1968) outstanding contributions to the field was that he enabled psychotherapists to be less self-critical about their mistakes and more human about their own lack of knowledge or self-awareness. Racker (1958) also contributed to reducing the omnipotent idealizations that therapists place upon themselves.

It has already been stated that consultation is a necessary requisite for all psychotherapists engaged in intensive work. One finding in this regard, which relates to women therapists in particular, arose from the fact that so many of the therapists expressed the wish to go on talking in the in-depth style of the interview. They enjoyed the kind of exploration and discussion that the interview encouraged. The interviews were deeply moving, stimulating and, at times, difficult to end. Several

suggested that there might be a group meeting to further pursue, in depth, some of the themes which emerged.

The author concluded that women therapists in this study, perhaps women in general, resonate in a particular way with each other. They have much to share, and many levels to reach. Even beyond the scope of their own therapy or analysis, these women need a place where they can continue to pursue intense and in-depth discoveries of themselves.

The request for ongoing discussion or dialogues by many of the therapists in this study seemed to signal a need which was underscored by the strong feeling that women felt they had unique issues to focus on, in terms of their own inner experiences and attempts at discovery and self-learning.

The major implications for clinical practice have been stated. Primarily, being open to one's countertransference (as were the female psychotherapists in this study), provides the richest basis for the psychotherapist's learning within the psychotherapy situation. What this study demonstrated is that there is a mutuality in the growth process for both the patient and the psychotherapist when the therapist is open to self-learning through awareness of her own countertransference.

The author views the situation of psychoanalytically oriented psychotherapy as an inherently creative process. If the resonance of the therapist is to understand the transference and countertransference, if respect and permission for choices and differences are inherent, and if the encouragement is towards mutual discovery, then psychotherapy is a creative process.

Rothenberg (1983) speaks of the creative process in psychotherapy; the psychotherapists in this study reflect the same sensitivity to exploration with their women patients that Rothenberg (1983) views as essential for creativity. As the therapists in this study demonstrated, the extent to which a therapist is able to look at her own feelings, allow for her own inner experiences, live with them, and, therefore, grow within the process, seems to be the extent to which the therapeutic endeavor will be rich, rewarding and creative for both patient and therapist.

One might infer from these comments that the author feels that women patients ought to seek treatment exclusively from women psychotherapists. Such is not the case. Male psychotherapists, of course, have much to offer women patients, just as women psychotherapists can successfully treat male patients. However, the author would speculate, based on this study and her own experience, that women patients do better with women therapists in certain life

stages and with reference to the treatment of certain life issues. The author views an individual's dynamics as the single most influential factor in their choice of therapist. Nevertheless, it is a uniquely interesting finding that when women speak to women, feelings which are intense and deeply moving arise for both. This is especially true when, as the study shows, the issues in the therapy pertain to the five major countertransference themes described in this study. The author posits that these themes represent a commonality of experience among women in this culture, and thus may be more appropriately worked through in treatment between women psychotherapists and women patients.

Implications for Further Research

This study suggests some cogent and vital areas for future research. First and foremost, the remaining question is: Should the choice of therapist or analyst be gender-related? Are women therapists and analysts able to understand women better because they share, in the sociocultural sense, a commonality?

Transference is said to know no gender. Yet it seems likely to the author that women patients may bring up different issues with a female analyst or therapist than they might with a male. Further, one can postulate that the resonance between a woman patient and a woman therapist differs in a qualitative way. Males and females in our

society are raised in distinctively different ways. While males in the early family setting are encouraged towards achievement, competence, and productive aggression, females are taught to be more caring, nurturant, and responsible to others. The impact of these gender differences on the course of treatment, as well as on the psychotherapist's countertransference, need further inquiry. A question might be posed as follows: Do women therapists offer greater validation for the aggressive, assertive, and ambitious aims of their women patients who are seeking to achieve new and different paths in their lives?

There are a series of additional questions which pertain to specific sociocultural aspects of the psychotherapist-patient relationship along the same lines of inquiry:

1. How does the extent to which a woman therapist has balanced her professional life with her personal relationships influence the course of the treatment with her woman patient?

2. To what degree has the women's liberation movement affected the roles of men and women in the institution of marriage, and in the family? Have men really changed their roles? Is a woman still the helpmate, the mother, the housekeeper, the social arranger, and cook, in addition to the career-achiever?

3. Does the awareness of new options for women, and the decisions and choices that awareness arouses, accentuate a woman's conflicts and, thus her passivity? Does pushing forward into a culture that may not be ready for her, losing what is behind her, and having to move back after all, turn out to be a worthwhile option?

4. Does the factor of having so many options both flood a woman and immobilize her, particularly with the struggles and attendant potential change, loss, and consequent aloneness that may confront her?

5. How does the stage of life of the female therapist influence the course of the therapeutic treatment for her women patients?

And finally,

6. Have the changes in role responsibilities for women been sufficient to enable women to have a career, a relationship, and a family, with comfort?

As well as dealing with a set of associated sociocultural issues, this study also prompts the author to pose the following questions about the intrapsychic and interpersonal components of the psychotherapeutic relationship:

1. Can the early determinants of the messages for achievement, ambition, aspiration, and success be found through a careful analysis of the transference and

countertransference relationship between women psychotherapists and their women patients?

2. Do women psychotherapists go into the field of mental health to repair their own maternal parent, and does this occur to an extent through their work with female patients?

3. Is the healing and repairing impulse of the therapist an appropriate or acceptable motivation for working with a patient?

4. How does the therapist's feeling that she has not lived up to her own creative and productive potentials influence the way she feels about the success of treatment with a female patient?

And finally,

5. What are the differences between women's conscious memories of early encouragement for curiosity, exploration, venturing, and, ultimately, separating, and their unconscious memories, which appear through the transference relationship to the analyst or therapist?

While the author has selected only a few of the intriguing questions for future research that emanate from this study, she is aware that many more areas of discovery may pique the interest of the reader. That is quite fitting when one considers that the original idea governing this study was the author's interest in discovering where women

obtain the earliest encouragement and permission for pursuit, inquiry, and discovery.

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# APPENDICES

APPENDIX A

INSTITUTE FOR CLINICAL SOCIAL WORK

INFORMED CONSENT FORM

I, _____, hereby willingly consent to participate in the _____ research project of _____ of the Institute for Clinical Social Work.

I understand that I may withdraw from the study at any time without penalty. I understand that this study may be published and my anonymity will be protected unless I give my written consent to such disclosure.

Date: _____

Signature: _____

WITNESS:

_____

APPENDIX B

QUESTIONNAIRE FOR FEMALE PSYCHOTHERAPISTS

Please respond to the following questions:

1. State your age at the time of this study _____.

2. Ethno-Cultural Background (Cau.__) (Blk.__) (Hisp.__) (Asian___).

3. Religion (J__) (P__) (C__) (Other___.

4. What is your orientation to psychotherapeutic treatment?

_____

5. Have you had psychoanalysis? If yes, please indicate orientation (Freudian, Jugian, Self-Psychology, Object Relations, Etc.) _____

6. Have you had psychotherapy? If yes, please indicate orientation: _____

7. Relational ties: (Please check one)

Married _____

Divorce _____

Single _____

Widowed _____

Children (Yes__) (No__).
If yes,

(a) How many? _____
(b) Their ages _____
(c) Gender _____

8. Family information:

(a) Please indicate your mother's occupation:

_____

(b) Please indicate your father's occupation:

_____

(c) Siblings? (Yes__)(No__). If yes,

Gender _____

Age(s) _____

(d) Was your family or origin: patriarchal _____

matriarchal _____

neither _____

(e) Was education and/or educational pursuits,

encouraged?_____ discouraged?_____ neither?_____

9. Psychotherapy experience:

(a) Years of experience: _____

(b) How many years in private practice? _____

(c) How many years in clinical or agency practice?

_____

(d) Do you provide supervision or consultation to other mental health professionals? If yes, indicate: (Yes__)(No__)

How many years? _____

(e) Do you teach other mental health professionals: (Yes__)(No__)

How many years? _____

10. What literature has been significant for you--current or past--in your psychotherapeutic treatment of women patients?

_____

_____

_____

## SUMMARY DESCRIPTION OF THE SAMPLE

Age:
- 35-39 = 2
- 40-44 = 2
- 45-49 = 5
- 50-54 = 4
- 55-59 = 7

Ethno-Cultural:
- Caucasian = 19
- Asian = 1

Religion:
- Protestant = 5
- Jewish = 9
- Other = 6

Experience:
- Psychoanalytic = 18
- Psychodynamic = 2

Years of Psychoanalysis:
- 0-4 = 8
- 5-9 = 10
- 10-14 = 2

Years of Psychotherapy:
- 0-4 = 11
- 5-9 = 7
- 10-14 = 1
- 15-19 = 1

Years of Psychotherapy Practice:
- 10-14 = 6
- 15-19 = 4
- 20-24 = 6
- 25-29 = 4

Children:
- 0 = 4
- 1 = 2
- 2 = 9
- 3 = 2
- 4 = 2
- 5 = 1

Mother's Educational Level:
- None = 1
- GS = 3
- HS = 5
- College = 11

Father's Educational Level:
- None = 4
- GS = 2
- HS = 6
- College = 8

Mother's Occupation:
- Professional = 3
- Business = 8
- Artistic = 2
- Housewife = 7

Father's Occupation:
- Professional = 3
- Business = 16
- Artistic = 1

Years of Consultation and Teaching Experience:

| | |
|---|---|
| 0-4 | = 4 |
| 5-9 | = 9 |
| 10-14 | = 6 |
| 15-19 | = 1 |

Marital Status:

| | |
|---|---|
| Married | = 12 |
| Divorced | = 7 |
| Single | = 1 |