SOME TECHNICAL PROBLEMS OF COUNTERTRANSFERENCE

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ABSTRACT

There are several aspects of the psychoanalytic interaction that foster the emergence of countertransference. First is a persistent identification with the patient, based primarily on the sharing of unconscious fantasies. Then there is the evocative power the patient's material may have upon latent unresolved conflicts in the analyst. Finally, the analytic setting itself may evoke a broad range of countertransference responses. Particular attention must be paid to those interventions of the analyst which represent attempts to divert his own and the patient's attention from emerging derivatives of the conflicts. There are many clues that should alert the analyst to the possibility of interfering countertransference.

There is a considerable difference of opinion as to what should be included under the heading of countertransference. My own views are closest to those expressed by Annie Reich (1951):

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

This definition describes countertransference in the narrow sense. On another occasion (1960), Annie Reich said:

One of the prevailing misconceptions is the equation of

counter-transference with the analyst's total response to the patient, using the term to include all conscious reactions, responses and ways of behaviour. This is as incorrect as to call transference everything that emerges in the patient in relation to the analyst during analysis, and not to distinguish between the manifestations of unconscious strivings and reality-adapted, conscious behaviour or observations. The analyst is for the patient, and the patient for the analyst, also a reality object and not only a transference or counter-transference object. There has to be in the analyst some (aim-inhibited) object-libidinal interest in the patient, which is a prerequisite for empathy. Conscious responses should be regarded as counter-transference only if they reach an inordinate intensity or are strongly tainted by inappropriate sexual or aggressive feelings, thus revealing themselves to be determined by unconscious infantile strivings (pp. 389-390).

Since this Panel's main interest is in discussing clinical material, I will restrict the presentation of my general comments to a number of seemingly dogmatic statements. There are several situations in the psychoanalytic interaction that foster the emergence of countertransference in individuals who are so disposed. The first occurs when the analyst identifies with the patient, in the sense that the patient's unconscious fantasies and wishes correspond to persistent unconscious fantasies and wishes of the analyst. Here it becomes necessary to distinguish between empathy and countertransference (Beres and Arlow, 1974). In both empathy and countertransference an identification is effected with the patient. In empathy the identification is transient, a temporary sharing of derivative expressions of the patient's unconscious fantasies and wishes. In the usual course of events, this is followed by a breaking-off of the identification, a separation from the patient. The experience of sharing the patient's unconscious fantasy derivatives serves as a clue to the understanding of the patient's conflicts (Arlow, 1979). In the case of countertransference, however, the analyst remains fixed at the point of identification with the

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is caught up in conflicts identical to those of the patient. Accordingly, the analyst becomes prone to the vicissitudes of these conflicts, and he may tend to act out or to respond defensively. Many people fail to make an adequate distinction between the transient identification that is characteristic of empathy and the persistent identification that leads to countertransference. It was an awareness of this confusion which led me to say that one man's empathy is another man's countertransference.

The effects of persistent countertransference identification are varied. The classic blind spot, i.e., the "refusal" or inability to "see" what the material is about, is only one form of response, and in my experience by no means the most common one. Actually, what is happening is that the analyst does not want the patient's material to remind him of his own unconscious conflicts. Therefore, he misses the interpretation or fails to give it, justifying his reluctance through various rationalizations. Additionally, there is a tendency to divert the patient from continuing the pursuit of derivatives of his unconscious conflict by some intervention which directs attention to other elements in the material, and also to assume a moralistic stance and to condemn in the patient what the analyst cannot stand in himself.

A second form of countertransference disturbance arises from the nature of the material that the patient presents. This may evoke fantasy wishes in the analyst not necessarily identical with the unconscious wishes of the patient. They may be complementary, as in the case of the patient's wish to be rescued and the wish of the analyst to rescue. In instances where there is a strong unresolved conflict operative in the analyst, material quite peripheral to the patient's central conflicts may nonetheless have an evocative effect upon the analyst's potential for countertransference.

And third, there are those instances in which something in the psychoanalytic situation as such is evocative of the analyst's conflicts. The wish to rescue has already been referred to. The analytic setting may represent a theater where the analyst may

play out some unconscious role of being the central performer to an admiring audience—an opportunity to display his cleverness or to use the analytic situation as a testing ground for his capacities. On the other hand, he may assume the role of the admiring auditor, unconsciously identifying with the patient. The physical conditions of the analytic situation, the patient supine, the analyst and/or the patient passive, may be read by the analyst in terms that stimulate unconscious wishes connected with passivity, masochism, etc.

In my experience, instances of the first category of factors predisposing to countertransference—i.e., persistent countertransference identification—are the most numerous. To illustrate this process, let me cite an example that I have published previously (Arlow, 1963). This material comes from the supervision of a candidate whose patient was a young, male, homosexual alcoholic. It was characteristic of the patient's behavior to ingratiate himself in a submissive way with strong men whom he admired and whose prowess he wished to grasp for himself during the act of fellatio. He corresponded to the type of homosexual patient described by Nunberg (1938) and by Anna Freud (1952), namely, the type of individual who submits his penis to be sucked, but who in fantasy identifies himself with the person sucking in an act of castrating the powerful man. Conflict over these wishes had resulted in many crippling inhibitions. The mechanism underlying the patient's perverse trends became understandable in a dream which the therapist reported during a supervisory session. In the dream the patient is lying on the couch. He turns around to offer the therapist a cigarette. The therapist had been having difficulties with this patient and had been nonplussed by this particular dream. At the point when he reported to me that the patient in the dream had turned around to offer him a cigarette, the candidate took one for himself, and, although he knew very well that I...
smoke, extended the pack to me and asked, "Do you want a cigarette?"

The reason for the candidate's difficulty with this particular

dream and with the patient could be understood by this bit of acting out. He had identified with the patient and, through this identification, had demonstrated a very probable source of countertransference difficulty, namely, the possibility that he and the patient had similar problems.

The second illustration is from the experience of a female therapist. The patient was a young professional woman, whose main difficulty related to her unhappy experiences with men. She had been married and divorced, had a number of stormy sadomasochistic relations with several men, one or two of whom were definitely criminal types, and presently was trying to get herself married to a man who had assured her from the very beginning that he had no intention of marrying her.

At this point in the treatment, the patient's conflicts concerning her younger brother had come to the fore. Interpretations had been based primarily upon sibling rivalry, growing out of competition for the mother's love and attention. Finally, the material demonstrated that there were other dimensions to the anger, in addition to the thought of having been displaced in the affections and attention of the mother. The associations revealed envy of the brother because he was a boy and resentment that she, the patient, had not been given a penis. In this context, there appeared hitherto unreported memories of trying to hurt the brother while he was in the patient's charge. When he was young, she would pinch him when no one was looking. Later, she would twist his arm and threaten him if he reported these acts to their parents. Several dreams were reported, of which this one is typical. The patient is taking care of her brother at the seaside, and they are walking near the surf. Suddenly a shark comes out and bites his leg, but also bites the patient's arm. Among her other symptoms, this patient complained of a fear of mice and insects. She was afraid of being bitten. This material, as well as other associations, made possible the interpretation of a hostile impulse directed toward the brother's genitals. The patient responded with a memory of reaching into her brother's diaper with the intention of feeling

his genitals, but the therapist did not carry the interpretation of the material any further. She did not point out the wish to grab the genitals and to eat them, although she was well aware of the nature of the patient's unconscious wish (cf., Arlow, 1963).

Earlier, the therapist had permitted the patient to rationalize the anger and envy of the brother in terms of dependency, frustration, and sibling rivalry for the mother's care. At this point, she rationalized her withholding the "deeper" interpretation in terms of waiting for the patient to state the wish herself in more explicit terms. When the handling of this problem was discussed with the therapist, she mentioned that she had a similar problem with a younger brother of her own, which apparently she had not fully explored or worked through in her own treatment. She was very appreciative of the insight that she got into the countertransference and was determined to handle the matter more directly.

What happened was striking. She pursued the subject, but in an aggressive, accusatory fashion. She was not satisfied that the patient could accept her interpretation of her wish to castrate her brother. Unwittingly, she was insisting that the patient actually try to recollect the wish to bite and to eat the genitals. She was treating the patient as if she were a sinner who could not be forgiven until the crime had been fully confessed. Accordingly, in the first stage of her problem, she was defensively fending off being reminded by the patient's material of her own impulses toward her younger brother. In the second part of her activity, having become aware of her identification with the patient, she was trying to make her feel guilty and remorseful for those wishes, as she herself must have felt at some earlier period. The discussion of this second phase of her countertransference response proved very

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effective. Once she dropped her accusatory stance (which had not escaped the patient at all), new and very important material began to appear. This material concerned memories of being in the parental bedroom and of observing the primal scene. The material indicated

that the patient wished to be in her father's position, having relations with the mother, and that she fantasied acquiring his phallus by eating it, in order to make it possible for her to fulfill the father's role in intercourse with the mother.

The third example concerns the supervision of a patient, a young physician who was struggling with his sexual role. He had powerful conscious homosexual impulses, which he could not accept. At the same time, he was extremely fearful of women and terrified of being trapped in any relationship with them. Supervision began five months after the patient had been taken into treatment, yet from the way the male therapist presented the material to me, it sounded as if treatment had only just begun. The preliminary material afforded some insight into the nature of the patient's difficulty. The patient spoke mainly of his mother, who was pictured as a cold, inhibiting, threatening woman. Metaphors revealing a fantasy of being sucked up and swallowed by machines gave us some insight into the nature of his unconscious fears. In addition, it was plain to see that the patient had a great fear of being tapped and a need to submit masochistically to men.

The first transference problem took the form of behavior concerning appointments. The patient kept trying to control the analysis by creating situations that would make it necessary for him to cancel sessions. Some of these could be rationalized in terms of his professional responsibilities, but other excuses seemed trivial, e.g., canceling his session so that he could give a party for his friends to watch a special television program, or taking long weekends or informing the analyst that he was going on vacation at a time other than the analyst's vacation, without discussing it in advance or seeing if he could rearrange his schedule. The candidate did not deal with this behavior as a problem, and when it was called to his attention, he seemed unable to call it to the patient's attention. Instead, he lapsed into a confused, helpless attitude, as if he were afraid to confront the patient. The patient responded by cutting more sessions for various reasons, until it reached the point where little analytic work could be accomplished.

I pointed out to the candidate that such behavior was incompatible with the pursuit of an analysis and also contrary to the analytic agreement. It was necessary to indicate this to the patient. This related interpretation promptly revealed the nature of the patient's underlying motivation. His behavior was intended to provoke the analyst, part of his deep-seated masochistic problem. In the following weeks, the patient kept repeating his provocative behavior in the form of bafflement, saying that he was not clear about the nature of the analytic arrangement, and would the analyst please explain it to him once again. He accused the analyst of treating him unfairly, even though nothing had been done. He kept misinterpreting the candidate's remarks. For example, when the candidate suggested that perhaps the patient could arrange for a change of schedule that would make it possible for him to take his vacation at the same time as the analyst, the patient reacted with the thought that when he came back from his vacation, the analyst would have terminated the treatment. In every way, in the patient's eyes, he was being threatened, accused, demeaned, and mistreated.

Instead of interpreting the misinterpretation of the interaction in terms of the patient's masochistic needs, the candidate kept trying to straighten out the "reality" of his statements and their interaction, without, however, stating explicitly what the psychoanalytic contract requires.

I tried to explore with the candidate why he had not pointed out to the patient how he was consistently recasting everything in terms of a fantasy of being assaulted or demeaned, as we had been discussing during supervision. He replied that the patient was not clear about the responsibilities regarding time and that he was
trying to explain it to the patient. Since I had not been present at the initiation of treatment, I asked him how he had set the terms of the analytic contract with the patient, and why he had not reminded the patient of those terms. What followed was a dramatic re-enactment in the supervisory situation of what had been taking place in the analytic situation. The candidate kept asking me for clarification as to what I wanted. He wanted amplification of the technical maneuvers, etc. I found myself repeating what I had told him in several different ways, until I pointed out to him that he was recapitulating with me in the supervision what the patient had been doing with him in the analysis. He recognized this immediately. It was clear to him that he had been identifying with the patient’s masochistic, provocative behavior, and was trying to get me to be angry and abusive toward him, very much as the patient was trying to get him to scold him and to throw him out of treatment. Once he stopped reacting to the patient, the nature of the material changed dramatically, and what emerged were associations concerning passive sexual wishes, first displaced onto a substitute transference object and then subsequently clearly directed toward the therapist.

In conclusion, I would like to make a few observations. First, much as we observe and study the patients, the patients do the same to us. They observe our reactions, often in order to ascertain what they can do to provoke gratification of their infantile strivings. The repertoire of behavior available to the patient for this purpose is enormous, but I would like to emphasize the role of silence (Arlow, 1961). By placing the burden of intervention on the therapist, the patient is able to get a good sampling of the spontaneous productions that the silence occasions in the analyst. Silence is one of the most effective instruments for stimulating countertransference responses in the analyst.

Secondly, I would like to point out that countertransference reactions and defenses on the part of the analyst are very often borrowed from the patient. Thus, there is possible a community not only of unconscious wishes between patient and analyst, but also of defenses against those wishes. In supervision, when some countertransference interference in technique is pointed out to the analyst, one can observe quite frequently how the analyst reacts defensively to the supervisor’s observations in the same way as the patient had responded to the analyst’s interpretations.

My final point is the importance of recognizing in ourselves indicators of countertransference reactions. Their manifestations are protean. Essentially, they all fall under the heading of loss of analytic stance. Most commonly discussed are the so-called “blind spots” that are picked up in supervision, feelings of confusion that persist when the analyst is unable to grasp the flow of associations, that is, a sense that he has lost his empathic contact with the patient. More dramatic and often more discussed are those examples of excessive emotion, loss of control, irritability, sleepiness, or boredom. Equally important are a number of indicators outside of the analytic situation that the analyst would do well to consider as evidence of possible countertransference involvement. Recurrent thoughts about the patient outside of working hours, especially those characterized by mood changes, such as depression, usually indicate the probability of some countertransference disturbance. The same is true if the patient appears in the manifest content of the analyst’s dreams or if there are intrusive fantasies centering on the patient. More subtle, but perhaps equally significant, is the tendency to recount events of the analysis or to talk to others about the nature of the patient’s problems, even when professional confidence is not breached. Finally, there are the well-known slips of the tongue and paraprases that occur in connection with the patient, particularly in scheduling, lateness, and forgetting of appointments. In general, the range of countertransference reactions is almost as wide and as varied as the transference reactions of the patients. The difference resides in the fact that much more attention is paid to the latter than to the former.