21. A Silent Partner to Our Practice: The Analyst's Character and Attitudes

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My hope in writing this paper is to sensitize therapists to look at a neglected area in our technique: the relevance of the analyst's character. I will arbitrarily divide the structuring effect of the analyst's character into three areas which overlap somewhat: (1) general attitudes; (2) analytic style proper; and (3) the analyst's reaction to specific situations. I will then focus on two narrow issues—the issue of parameters, and that of the transference neurosis.

Occasionally, we take the liberty of making simplifying assumptions in order to conduct experiments or research. Only later (at times, at the cost of bitter experience) do we become aware of the liability of such a strategy. In the Dora case, Freud made such assumptions. He unwittingly took the position that attitudes and the character of the patient (and himself) could be safely ignored and that he could count on her cooperation in his search for the meaning of her symptoms and dreams. It is a tribute to Freud that he could learn from his errors and make major discoveries as a result of the difficulties his nonverbalized assumption created for him; in this case, the loss of the patient allowed him to discover the concept of transference.

A large bulk of our technical writings adopts the simplifying assumption of the average expectable analyst who will "apply" appropriate technique of principles, such as the rules of abstinence. This approach bypasses the character and subjectivity of the practitioner in order to focus on the content of the method. I do not believe I am overstating the case in seeing the purpose of technique and its structure as an effort to tame the personality of the analyst so as to allow psychoanalytic work to be done. The issues in this paper can be seen both as the impingement of character on technique and as the impingement of technique on the analyst's personal attributes.

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THE ANALYST'S CHARACTER AND ITS EFFECT ON TECHNIQUE

By character, I refer to the broadest attributes of a person, ones that are generally self-syntonic. This list includes values (ethical and otherwise), therapeutic stance, and general traits (such as impulsivity and optimism) which are specific and stable. Some of these traits may be more conflictual than others; others may merge on the symptomatic.

In what follows, I will closely examine issues of technique with the analyst's character as an organizing factor. One advantage of the concept of character is that it subsumes both the normal and the abnormal and includes both what is stylistic (the form of the analyst's manner in contrast to its content) and what is generally subsumed under the label of countertransference. Bearing in mind the neutral aspects of character, we are not forced to make premature judgments about the pathological aspects of a particular response.

In the title of this paper, I have purposely used the terms *character* and *attitudes* because character (in the sense of character traits) is primarily something observed from the outside by another person. Attitudes, on the other hand, refers to a mind set—primarily, internal attributes. Thus, an attitude will determine behavior which will then be perceived by an outside observer. The latter will then infer (correctly or not) some character trait.

Character traits are combined to form the character organization—a stable, coherent structure. It is possible to describe the latter along a variety of axes, depending on one's preferences—object relations, drives, defenses, developmental, adaptational and the like. Because of the ambiguity of the term character, I will sometimes consider the analyst's character as referring to an external attribute—something the patient observes, and sometimes consider it from the inside realm—a structure which lends form to the analyst's perceptions and shapes his view of the world.

How does the analyst's character permeate his technique? This broad topic may, for the sake of convenience, be broken down into three sections: (1) his self-syntonic general ways of being, which express the analyst's values and attitudes: pessimism or optimism, permissiveness, tendency to gratify or frustrate wishes; rigidity or flexibility, degree of activity, degree of warmth vs. distance, passivity, and so forth; (2) analytic style proper—formal attributes apart from the content of interpretations; such things as tone, manner, verbosity, use of humor, authority, and readiness to make interpretations or

reconstructions; (3) the analyst's specific reactions to affects of the patient such as anger, criticism, love, or problems in treatment (for example, stalemate).

THE ANALYST'S GENERAL ATTITUDES

It is very difficult to disentangle an analyst's professional behavior from his character. Although technically speaking, his behavior as an analyst reflects his professional and therapeutic stances, its very stability is by definition part of his character. These attitudes color the ways he conducts the analysis as a whole. Permissiveness and gratification of wishes are good examples. An analyst who, in a given instance, does not answer a patient's questions and clearly frustrates him, may do so for a variety of motives which only analysis (or self-analysis) may reveal. He will hopefully do so because he believes it is in the patient's best interest even though the patient experiences rage or anxiety as the result. In accordance with the principle of multiple function, such behavior will also have its unconscious significance, often not, by the way, dealt with by the training analysis.

The analyst may unconsciously express his sadism or possibly take revenge against what he perceives as an ungiving patient. The opposite might also be true; an analyst who is too ready to answer questions may do so out of a fear of provoking aggression. We would expect that a reasonably well-analyzed therapist would be somewhat cognizant of the influence of his unconscious motives. To the degree he is not, these motives could then cause difficulty. In the case cited, they might interfere with a proper therapeutic stance: the therapist might remain silent when it is more appropriate to interpret, rationalizing his stance on the basis of the rule of abstinence. Even knowledge of one's own unconscious motives and character attitudes does not necessarily put the analyst in a position to do something about them. Character responses seen from the inside are, for the most part, forced choices of an automatic nature not open to question. They are like a pair of colored glasses one is not free to remove. It is possible to describe these general attitudes both as mind sets—predilections for certain reactions—or as sensitivities to certain constellations and the readiness of their being evoked in the analyst. This includes both cognitive and affective reactions.

Values characteristic of the person's *Weltanschauung* may have been especially influenced by early experiences. For example, childhood illness or trauma which was surmounted may promote a belief, not clearly masochistic,

that certain sufferings are valuable and growth promoting or that given a choice, the hard way is preferable.

There must be a complicated relationship between the way an analyst was treated as a child (for example, strictly or permissively) and his adult attitudes, varying with the outcome of his analysis and the resolution of infantile identifications. There is still another step concerning his adult attitudes to his analytic demeanor. A "strict" personal predilection may, because of many different motives, lead to a permissive stance. Reaction formations may color the end result.

A number of separate attitudes will converge to determine a particular stance; for example, how silent the analyst ends up being is determined by a combination of attitudes of permissiveness, rigidity, gratification of wishes, and activity, to name but a few. I am leaving out for the purpose of this presentation the learning the analyst has acquired during his training and the identification he may have made with his supervisors and the thoughtful integration of the above into what will eventually turn out to be his personal style. I am also leaving out the major impact of the identification with the training analyst—his values and attitudes and the degree to which the analysand accepts or rejects them and works through this aspect of his professional identification. These last purposive acquisitions may themselves be involved in conflicts. It is common knowledge that as an analyst gains more experience, his professional attitudes change. He often can become less rigid, less concerned about rules and their infractions, and more willing to reveal certain personal attitudes.

THE PROBLEM OF ANALYTIC STYLE

I have not ceased to be amazed by both stories and vignettes of what well-known teachers and respected analysts could do within the limits of their style without apparent major difficulties. One now-deceased senior analyst was well known to touch certain depressed patients during the course of therapy. As an expression of love, warmth, and caring, this parameter may have been very useful and when applied, it was very likely experienced as nonintrusive. I could imagine a student trying to learn technique copying this analyst's approach and getting disastrous results. Another analyst who used to share a suite with a fellow therapist confided how often he would hear his colleague yell at his patients through the soundproof door. To him, this did not sound like anger, but rather in this instance a demonstration of loving

and concern. The problem with such issues of style is that they are hardly, if ever, analyzed, and the patient's responses to them are often misunderstood or glossed over.

What are the components of analytic style, the subtle formal aspects in contrast to the content of interpretations? Many variables exist, such as intonation (degree of uniformity), manner, humor, drama, verbosity vs. pithiness, conviction vs. tentativeness, use of authority, and many more. Such elements are the counterpart of the patient's style and it is important for the analyst to be aware of their presence and potential impact. The degree of tonal uniformity, to take but one limited example, may be described in very different ways: even, bland, lackluster, stable, restrained, neutral. The choice of these adjectives carries with it a value judgment: "neutral" the least and "bland" or "lackluster" the most. This is true in general of all descriptive terms applying to character. We tend automatically to see a trait as good or bad. Yet even the term neutral can be thought of as signifying both a negative (absence of criticism, judgement and the like) and as positive (making understanding possible implies certain therapeutic values). There are clearly instances where a departure from a neutral tone is called for, especially with patients whose style superficially mirrors this stance. An example is the stubborn obsessional isolator who uses the analyst's tone to further his own distance from the interpretations. "You remain neutral so why shouldn't I?"

STYLE AND RESISTANCE

There are important differences in the degree of activity of the analyst not explained by rules. I have heard the humorous epithets of hunters vs. trappers in describing two extremes of stylistic approach! On a personal note, my second analyst's rather loquacious manner allowed me to take distance from and realize the impact of my first analyst's scant verbal pronouncements—clearly a stylistic difference which had a major effect on the course of the treatment. For some patients, the analyst's style seems to matter very little; it is hardly ever mentioned in the treatment. This may or may not represent an avoidance on the patient's part. I have in mind two patients. The first patient felt very needy of help and quickly developed an intense transference neurosis characterized by the emergence of a new symptom, impotence; he was able to associate well and dreamed profusely. He was in many ways an "ideal" analytic patient. He did not make chronic repetitive battles out of the formal aspects of what I said although, amusingly enough, he picked up

almost in passing a small grammatical error I had made in the recording of my voice on my answering machine! In contrast, a second patient, generally mistrustful and cautious, focused very early in the treatment on one aspect of my personal style. As English is not my first language, my speech is often a bit precise, stilted, and clearly enounced. She latched on to this quality which she began to attack mercilessly, and would giggle and laugh at occasional pronunciation errors I might make or grammatical oversights (a very provoking attitude on her part I might add). In fact, the content of what I said was hardly ever the focus of her concern. No matter how I tackled this attitude—its functions in the here and now, such as turning the tables on me, focusing on my imperfection, dreading a closeness to or fearing to be influenced by me—the treatment made little progress. A certain similarity between my speech and that of her mother served as a hook for a very sticky transference which could only be very partially resolved. It would be too easy to dismiss this case by saying that the speech problem was coincidental or that the patient would in all likelihood have focused on some other issue to maintain her character defenses. I suspect that the accidental similarity between my speech and her mother's made it more difficult for the patient to see her attitude as essentially transferential, a point I will return to later. I believe patients are often intimidated by aspects of our style which they sense are invested with considerable narcissistic libido and are therefore not open to question. A patient once told me he was afraid of freely expressing his thoughts because of what he understood to be the "No Trespass" sign of his previous therapist's attitude towards all his patients: he would never get up and greet the patients in the waiting room but would simply leave his door ajar as a signal, making it the patient's responsibility to keep watch on the door's position.

Gill has written on the value of paying close attention to resisted aspects of the transference; however, our own taking for granted certain self-syntonic aspects of our style requires a constant vigilance on our part not to miss the way patients react to it.

THE ANALYST'S REACTION TO SPECIFIC SITUATIONS

This category—the analyst's reaction to specific situations—is the more familiar countertransference examined from the characterological point-of-view. How does the analyst typically react when he feels attacked, criticized, loved, idealized, or stuck? Such issues are more often taken up in the personal analysis than the other categories because they lead to obvious conflict in the analyst. I shall have less to say about them as there is a vast literature on the topic. Glover in his textbook on psychoanalysis refers to the silent resistances and counterresistances—the most dangerous—for obvious reasons. He gives a clue as to their appearance—when the analyst is tempted to or does actually depart from his usual way of doing things. Examples include the way patients are ushered in or out of the office, the ways bills are handled and so on. I will deal, however, with one specific aspect, that of parameters.

In what situations does an analyst feel the need to introduce a parameter in an ongoing analysis? The answer is fairly obvious. It is in those situations in which the treatment appears stuck and where, in the opinion of the therapist, interpretation is useless or harmful. Often there is some state of crisis or stalemate. Let me cite a well-known example, looking at it from the point-of-view of the analyst's character structure.

A deceased well-known colleague once told a group a most fascinating vignette about a very wealthy patient he had been treating in Paris before the war—some time in the early thirties. Money meant nothing to her. After some time, the treatment seemed stuck. All the interpretations of the patient's resistance, aggression, and contempt failed to resolve the impasse. The analyst then announced one day to the patient that until further notice, he had decided not to charge her a fee! Surely, a very dramatic gesture, which, as he tells the story, had a dramatic impact. The patient was very much shaken and the treatment moved forward again after months of stalemate. It would seem to me to rob our understanding of this intervention if one failed to take into account certain "characteristic" attitudes of the analyst in question which became apparent as I came to know him over many years—his willingness to sacrifice himself, his capacity for *le beau geste*, and many other traits. We can only imagine what he may have experienced prior to the introduction of the parameter—chagrin, anger, frustration, helplessness, or some variation of these affects according to his particular sensitivity and character structure, along with curiosity, puzzlement, and so on. His casual comments about the incident left no doubt that even in an informal setting he did not think it of much relevance to refer to his own personal attitudes in discussing either the crisis or its resolution, leaving his audience in an affective state combining awe, admiration, and envy! My point is not simply to identify character traits for their own sake, but to demonstrate what we lose in our explanatory and descriptive potential when we leave them out of

our formulation. Consideration of character leads, of course, to thorny, perhaps unanswerable questions which need to be asked. Was the above situation stuck because of the analyst's blind spot and could one say that the dramatic gesture represented his (preconscious?) solution to his characterological problem in the treatment?

It is very instructive to read the early cases in the analytic literature, as they often illustrate very well the point I made early in the paper: the absence of a well-developed technique has as its counterpart the greater flourishing of more personal (that is, characterological) reactions on the part of the analyst. The principle of neutrality is in a sense a safeguard for the analyst against too personal an intrusion.

CHARACTER AND TRANSFERENCE NEUROSIS

The topic of character and transference neurosis deserves close attention. The concept of transference neurosis as developed by Freud between 1910 and 1920 did not consider character issues but concerned itself more with neurosis; that is, an encapsulated illness in an otherwise normal personality organization. Symptoms were its hallmark. For the purposes of this presentation, I will dwell on the analyst's contribution to the development of the transference neurosis as seen from the point-of-view of his *character* and *attitudes*. I refer to both terms, as the problem of transference neurosis can be studied both clinically (how is it experienced by both participants) and theoretically (how do we conceptualize its structure). The transference neurosis is not limited to symptoms, yet it is not clear which attitudes of the patient will become manifest and which aspects of the analyst's attitudes will become the target of the patient's attacks. I would like to think that the more conflictual aspects of the patient's character traits will occupy center stage. Freud (1916) wrote: "What opposes the doctor's efforts is not always those traits of character which the patient recognizes in himself and which are attributed to him by people around him. Peculiarities in him which he had seemed to possess only to a modest degree are often brought to light in surprisingly increased intensity or attitudes reveal themselves in him which had not been betrayed on other relations of life."

Brian Bird (1972) makes, amongst others, the following points: Only when the analytic situation becomes, in a sense, an adversary situation, should we expect the kind of transference neurosis to develop that can admit to it a

representation of destructive impulses strong enough and faithful enough to permit this aspect of the patient's neurosis to be effectively analyzed. The analyst, through the analytic process, must somehow enable the patient to extend his intrapsychic conflicts to include the analyst (p. 295). In order for this to happen, Bird believes the analyst's own transference involvement is necessary. For one thing, his own transference may be the factor that enables him to accept an adversary role in the patient's neurosis (p. 296). When the transference neurosis finally develops, neither patient nor analyst may realize for a while that it has. What they will very likely realize is only that the analysis has been caught up in a stalemate, a negative therapeutic reaction, a strong unmovable resistance, or some other seemingly impossible negative struggle between patient and analyst.

I am in full agreement with Bird's findings, but would like to restate them in characterological terms. At the point just mentioned by Bird, there is a particular engagement between the character attitudes of the patient and the character attitudes of the analyst. At those times, I transitionally often experience a certain helplessness, as though I were caught up in the patient's way of subtly distorting the situation between us. When I examine myself further, I often find the kernel of truth in the patient's accusations which leads me to be caught up in his subjectivity ever so briefly.

SOME CLINICAL EXAMPLES

An example will clarify. A psychotherapy patient with homosexuality and a severe masochistic perversion came to sessions at times somewhat inconvenient for him. I could have changed his hours, but had not on the basis that I did not think the inconvenience that great for him and wanted to keep open the more desirable hour for a case in more intensive therapy. One day, the patient, somewhat to my surprise, exploded in a paranoid-like rage, saying I was taking advantage of him in not attempting to change the hour and that I must have known I could push him around and that he would do nothing about it. Some self-reflection immediately confirmed the kernel of truth in his accusation; namely, if he had categorically stated the hours were impossible and interfering with his work, my attitude might have been different. One could say that his sudden outburst—a repetition of life-long fights he had had with his psychotic mother, triggered off some transitory guilt reaction in me, temporarily blinding me to the other components behind the

patient's attack (for example, the self-loathing). This was possible because of my transiently accepting an identification with a bad object, in this case, the mother who mistreated him.

When Bird is referring to the transference neurosis, I believe, as I have written elsewhere, that one has to include in the term a character portion for it to have any meaning. It is at this point that analyst and patient really "lock horns." There is a strong mutual affective involvement in contrast to that occurring during aspects of the analysis of the transference which does *not* involve the analyst in the same intense way.

By the term "locking horns" I believe Bird means that the analyst has to feel that in some way the patient is "getting to him" for the work to really come alive for the patient in the experience of the transference neurosis. I suspect that the analyst's real character traits serve as hooks on which patients can "hang" their transference reactions. In fact, patients hungrily seek out the analyst's character—in part, as an effort to reach out, to make contact as compensation for the analyst's abstinence. If the patient engages the character of the analyst at a point in which the latter is vulnerable or sensitive, the treatment may not make progress at that point.

I recall also an incident from the analysis of my first treatment center patient. For considerable parts of the analysis, she came late, missing anywhere from ten to forty minutes. Although I attempted to "analyze" her lateness, the treatment made little headway on that issue. My supervisor and I puzzled on this until one day in my personal analysis, I confronted the fact that first, I enjoyed the lateness of this patient as it allowed me to catch up on other work and that further, I felt it almost my due; that is, it served as a compensation for the negligible fee (one dollar) she was paying me and the considerable skill with which she was demonstrating my greenness as a student analyst. I am not sure I could pinpoint exactly what changed in my analytic listening or interpretations, but shortly afterwards, the lateness ceased. As best as I can reconstruct it, the consequences of my awareness of my resentment were that I was able to effectively combat a slight withdrawal from the patient. I could be more sensitive to important nuances of her communication by focusing less on her aggression towards me—real enough, but which I had overly interpreted as a screen for my own resentment towards her. My withdrawal had mirrored in some small way her narcissistic mother's treating her like an object. A conflict was, therefore, played out rather than analyzed.

THE PRINCIPLE OF COMPLEMENTARITY

It is in the nature of characterological behavior that it stimulates in the audience a specific reaction. This reaction is a combination of the demand that the behavior makes and the recipient's sensitivity and characteristic mode of functioning.

This is the principle of complementarity first written about by Helene Deutsch in 1926 and elaborated by Waelder. Briefly stated, a character attitude in one person has as its effect to stimulate either a mirror or an opposite reaction in the other person who is the target of it, this depending on the latter's character style. Sadistic or aggressive behavior may stimulate counter-aggression or compliance. Procrastination or stubbornness may stimulate a form of nagging; whining or helplessness may stimulate aggression or caring. This is in part the appeal function, generally unconscious.

In writing further on the range of identifications an analyst makes with his patients, Helene Deutsch differentiates two types: one is the so-called concordant identifications, which enable the analyst to put himself in the place of some aspect of the patient in the service of the wish to understand; in contrast, there are the complementary identifications—those are made with the patient's internal objects according to the prevailing transference fantasies. This occurs largely out of the analyst's control.

The former identifications pose no danger to the analyst's objective attitude of observation, whereas in the second type, the analyst is emotionally involved in the situation. The experience is felt by him with great intensity as a "true" reality. The analyst may respond to this situation by perceiving his reactions and using them in his interpretive work or by acting out alloplastically or autoplastically (such as by feeling guilty or by acting angrily or defensively in the case of an attack by the patient). Such activation of the analyst's character traits and complementary identifications, far from being a hindrance to analysis is, in my view, a central part of the transference neurosis experience. This is particularly true in patients with sadomasochistic features, in which the analytic situation will at some point involve an adversary relationship.

To a minimal degree, the activation of a character response in the analyst puts him at a crossroad in the paths of acting out versus understanding. The analyst's ability to do the latter is a function of his inclination to anxiety,

guilt, pathological defenses and the like. There is, unfortunately, a possibility that the function of certain of the analyst's character traits either block or distort his perception of the patient's communication or affects or that the analyst perceives correctly but that he can only react neurotically. The question may be asked, "What motivates a particular character response in any person?" The answer has to be some aspect of the situation for which the character reaction is a solution. This is as true for the analyst as it is for the patient. One of my supervisees had developed certain passive compliant attitudes as a solution to an aggressive conflict with a dominant parent. Whenever a patient behaved in an aggressive demanding fashion, the form of the supervisee's response would be clearly compliant regardless of its content.

SUMMARY

At present we are lacking a proper framework to describe the impact of the analyst's character on the analytic process. I believe that our character shapes our work more than we are willing to admit beyond the usually considered countertransference reactions. I have attempted a brief overview of this topic including issues of style, general attitudes, and introduction of parameters. I have also begun to explore the role of the analyst's character in the development of the transference neurosis and have appended a few clinical illustrations.

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22. Therapeutic Problems in the Analysis of the 'Normal' Candidate

Maxwell Gitelson

I

In order to consider the problems of the psychoanalytic situation in which the 'normal' candidate becomes involved, it is necessary to have in mind a conception of mental health. Only when we know what our goal is can we consider the technical problems confronting the training analyst. We assume that it is not simply a question of freedom from symptoms or of 'social' adjustment. It is understood that we are concerned with normality from the standpoint of psycho-analysis.

Ernest Jones approached the question in an essay which was originally intended for general readers.[1] He referred to two main groups of definitions of normality: (a) those depending on the criterion of *happiness* and (b) those depending upon *adaptation* to (psychological) reality. The latter 'does not necessarily imply the acceptance of environmental standards, but it does imply a sensitive perception of them and a recognition of their social significance'. This depends on a 'feeling relationship' with other human beings, which 'is to be estimated by the internal freedom of such feeling' as distinguished from surface attitudes of conciliation or self-assertion.

Midway between the concept of happiness and the concept of reality adaptation Jones introduced the concept of *'efficiency'*. This concept depends on a number of factors: normality cannot tolerate a state of excessive influence by others; nor can it dispense with sensitiveness to others; it is dependent on what Jones calls *'gusto';* it is not concerned solely with external success, but it does require the fullest use of a given individual's powers and talents. The one is born of confidence, the other of fear.

Against this background Jones came to the conclusion that the state of

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