THE TECHNIQUE OF PSYCHOTHERAPY

THE MANAGEMENT OF UNTOWARD ATTITUDES IN THE THERAPIST, INCLUDING COUNTERTRANSFERENCE

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Two people locked up in the same room are, sooner or later, bound to find their difficulties rubbing off on each other, each personality influencing the other. The patient will regard the therapist in many ways, such as (1) an idealized parental figure, (2) a symbol of the parents and of authority, and (3) a model after whom one seeks to pattern oneself. A therapist too responds to a patient in various ways. There is a tendency to project onto the patient one's own prejudices and values as well as to identify the patient with inpiduals from one's own past. The therapist's reactions are bound to influence those of the patient. In recognition of the fact that a therapist cannot truly act as a blank screen, no matter how thoroughly adjusted one is, many therapists have devoted themselves to a delineation of the clinical effects of what they have called *countertransference* (Balint &Balint, 1939; Berman, L, 1949; Bonime, 1957; Cohen, M, 1952; Gitelson, 1952; Heiman, P, 1950; Little, M, 1951; Orr, 1954; Rioch, 1943; Salzman, 1962; Tauber, 1964; Winnicott, 1949; Wolstein, 1959). The importance of countertransference is that it influences all forms of psychotherapy—supportive, reeducative, or reconstructive—sometimes to their detriment, sometimes to their benefit.

The idea that countertransference is always bad has in recent years been revised (see Chapter 57). Countertransference may be used in a therapeutic way. Therapists, recognizing that their own neurotic feelings are being activated, may look not only into themselves, but also into what neurotic needs and drives in their patients are activating in their personal reactions. They may then bring up these provocations as foci for exploration. They may ask, "Is the patient aware of aberrant impulses and behaviors? What does the patient want to accomplish by them?" Confronting the patient with the behavior may have a therapeutic impact.

Accepting the benefits of some countertransference reactions, we shall in the remainder of this chapter concern ourselves with its negative effects that account for a great many failures in psychotherapy.

Conceptions about countertransference are multifaceted. These range from the traditional idea that

it is exclusively confined to feelings derived from repressed unresolved parental attachments (Winnicott, 1949) to strivings provoked by anxiety (Cohen, M, 1952) to the total range of attitudes of the therapist toward the patient (Alexander F, 1948). The tendency to dilute countertransference with reactions emerging from the habitual character structure has created some confusion. Befuddement also comes from the tendency to identify all positive or negative feelings toward the patient as forms of countertransference. The therapist as a functioning human being will have a warmth toward, a liking for, and empathy with patients—more with some than with others for realistic reasons. The therapist will also be candidly angry with certain actions of patients, the display of which toward the patient may not at all be destructive. Indeed, the patient may be traumatized by the therapist's failure to respond to provocations with justified indignation or rage. However, the reactions we are concerned with most in psychotherapy are responses of the therapist not justified by reality but which issue either out of the therapist's own transference or that emerge as expressions of the neurotic character structure. Therapeutic manipulations fostered by the therapist's needs, rather than by those of the patient, are bound to create rather than to solve problems (Lorand, 1963a).

Where disciplined in self-observation, the therapist may become cognizant of troublesome attitudes and feelings toward patients before expressing them in behavior. The more insight one has into one's interpersonal operations, the more capable one is of exercising any necessary control. Where there is little understanding of one's unconscious dynamisms, the therapist is most apt to respond with unmanageable negative countertransference.

An illustration of how countertransference may act to the detriment of therapeutic competence may be cited by the case of a male therapist who, well trained and endowed with more than the usual warmth toward people, was able to achieve good results in psychotherapy with most patients. Notably defective, however, were his results with male patients who had serious difficulties with women. The therapist himself was involved in conflict with his wife, the details of which he was not at all loath to verbalize. This was undoubtedly a manifestation of his unresolved problems with women. Whenever his male patients pulged their difficulties with their wives, the therapist would immediately respond with rancor and vehemently denounce the chicanery of scheming females. This attitude, while temporarily comforting to some patients, ultimately resulted in their distrust of the therapist, engendered by a realization that they could never work through with him some of their basic life problems.

It is rare indeed that a therapist, irrespective of how free one is from personality blemish, can respond with completely therapeutic attitudes toward all patients. With some patients one may display an adequate degree of sensitivity, flexibility, objectivity, and empathy, so helpful to good psychotherapy. With other patients one may manifest a lack of these qualities and an inability to perceive what is happening in the treatment process. There will be a failure to recognize neurotic projections in the relationship, and to remain tolerant in the face of the patient's irrational and provocative behavior. Thus, infantile requests by the patient for exclusive preference, or sexual responsiveness, or expressions of resentment and hostility, or unfounded complaints of being exploited, may bring out in the therapist attitudes that interfere with a working relationship.

> If the analyst cannot identify with the patient, he will encounter difficulties, but identification in turn leads to other difficulties ... the analyst then experiences the patients' intense anxieties fears, rages, lusts and conflicts as his own, and unless he faces these problems and deals with them directly, he may resort to controlling devices to allay the patient's anxiety and his own—such as excessive tenderness or other devices similar to those employed by the patient's parents, or he may resort to primitive defenses similar to those used by the patient, especially paranoid defenses. (Savage, 1961).

Character distortions in the therapist will inevitably have an effect on the patient. Thus, a need in the therapist to be directive and authoritarian, while advantageous in supportive approaches, tends, in insight therapy, to interfere with the inpidual's growing sense of self, expanding assertiveness, and independence. Authoritarian attitudes also pander to dependency strivings in the patient and coordinately nurture rebellious tendencies. Some therapists are driven by pompousness to make too early and too deep interpretations, which they hope will impress the patient with their erudition and perceptiveness. They may also attempt to force the patient into actions before the latter is ready for them. However, this playing of a directive role with the patient to satisfy certain emotional needs in the therapist must not be confused with a deliberate extension to the patient of emotional support when this is therapeutically indicated. The former is usually based on the motivation to parade one's power and omniscience; the latter is a studied, measured giving of help that is inspired by the needs of the patient.

Tendencies toward passivity and submissiveness in the therapist may also have a detrimental effect on treatment since it is sometimes necessary to be firm with the patients, as in helping them to avoid retreat, to execute insight into action, and in offering them essential guidance and reassurance. Submissive traits in the therapist, furthermore, operate to bring out sadistic, hostile attitudes in the

patients.

Impulses toward detachment may develop in the therapist as a defense against entering into close contact with some patients. This trait is particularly destructive to the therapeutic relationship. The patient may be able to establish some sort of relatedness with a domineering or a passive therapist, but is totally unable to relate to one who is detached.

A therapist who, because of personal anxiety or a depriving life situation, is thwarted in the expression of certain basic drives may attempt to live through them vicariously in the experiences of the patient. The therapist may, therefore, tend to overemphasize certain aspects of the patient's behavior. Thus, if the patient is in a position of fame, or is financially successful, or is expressing sexual or hostile impulses, the therapist, if there is the unconscious need to satisfy such strivings, will focus unduly on these perhaps to the exclusion of other vital psychic aspects. This loss of perspective is particularly pronounced where there is any overidentification with the patient.

Neurotic ambitiousness may cause the therapist to glory in the patient's accomplishments and to push the patient inexorably into areas that are calculated to lead to success and renown. Overambitiousness may also be extended toward seeking rapid results in treatment. Here the therapist will be unable to wait for the gradual resolution of resistance. Accordingly, the exploratory process will be promoted too hurriedly at the beginning of therapy. Perturbed by the slowness with which the patient acquires insight, the therapist may interpret prematurely, and then respond with resentment at the oppositional tendencies of the patient. The therapist may also propel the patient too vigorously toward normal objectives and then become frustrated at the patient's refusal to utilize insight in the direction of change.

Due to anxiety or guilt, it may be difficult for the therapist to countenance certain needs within himself or herself. When such needs appear in the patient, the therapist may exercise attempts to inhibit their expression. Difficulties here especially relate to impulses toward sexuality, hostility, and assertiveness. Should the patient introduce these topics, the therapist may act disinterested or may focus deliberately on another area. The therapist may be unaware of these personal psychic blind spots that prevent exploring anxiety-inspiring conflicts in the patient. Thus, a therapist who has problems in

dealing with hostility, may, upon encountering hostile expressions, reassure the patient compulsively or channelize verbalizations toward a less threatening topic. Fear of hostility may also cause the therapist to tarry, to lose initiative, and to evidence confusion on occasions when the patient attempts to act in an aggressive or assertive way. Fear of special aspects of the patient's unconscious may cause the therapist to circumvent the discussion of pertinent material to the detriment of reconstructive therapeutic goals.

Other limiting personality manifestations may reflect themselves in neurotic attitudes toward money with an overemphasis of fees and payments, in an inability to tolerate acting-out tendencies in the patient, and in a tremendous desire for admiration and homage. Perfectionistic impulses may cause the therapist to drive the patient compulsively toward goals in treatment that are beyond the patient's capacities. At times some therapists, under pressure of their own neurotic drives, may set up a situation in treatment that parallels closely the traumatizing environment of the patient's childhood. When this happens, the patient's transference may become extreme and perhaps insoluble. Certain patients may mobilize in the therapist strong feelings of rejection and intolerance, which will destroy the emotional climate that is so important for personality development. Other therapists, burdened with narcissism, and needing to impress the patient constantly with their brilliance, may utilize interpretation too freely and water down the therapeutic process with intellectualizations.

It must not be assumed that all neurotic displays on the part of the therapist will have a bad effect. If they play into the patient's immediate needs, they may bring the patient to a rapid homeostasis. Thus, a sadistic therapist may be eagerly responded to by a masochistic patient. An authoritarian, domineering therapist may satisfy the dependent impulses of a depressed person. Restoration of equilibrium will not, of course, alter the basic personality structure. Important to consider also is that growth in a psychotherapeutic relationship with a neurotic therapist may occur in patients with essentially good resources. Such patients will select out of positive aspects of the therapeutic situation elements that they can utilize constructively. They may rationalize the therapist's neurotic weaknesses, or not pay attention to them, or simply blot them out of their cognitive field. It is to be expected that perceptive patients will eventually discover some neurotic patterns or traits in their therapists. This may at first result in disillusionment, anxiety, resentment, or insecurity. If the relationship is a good one, however, there need be no interference with the therapeutic process, the patients ultimately adjusting themselves to the reality of a less-than-ideal therapist image. It may actually be helpful to discard the mantle of perfection

with which the therapist has been draped in the early part of therapy. The degree and kind of neurotic disturbance in the therapist is what is important.

At certain phases in treatment therapist improprieties may become more pronounced than at others. For instance, during periods of resistance the therapist may respond with aggressive or rejecting behavior. Some actions of the patient may also stimulate countertransference. A patient who is frankly seductive may stimulate sexual feelings in the therapist; one who is openly antagonistic may precipitate counterhostile attitudes. The patient may be sensitive to the moods of the therapist and work on these for specific gains, the most insidious effect of which is a sabotaging of the treatment effort.

Because countertransference may result in therapeutic failure, it must be handled as soon as possible. Where recognized, the therapist may be able to exercise some control over it. There are therapists, who, though unanalyzed themselves, have an excellent capacity for self-analysis and an ability to restrain annoying expressions of countertransference. This permits the therapeutic process to advance unimpeded. A therapist who has undergone successful personal psychotherapy or psychoanalysis will still be subject to countertransference from time to time. Nevertheless, one should, by virtue of one's training, be capable of detecting and of managing troublesome reactions as soon as they develop.

Instead of denying a neurotic response to the patient, which is so common, some therapists, detecting their own untoward responses, admit them openly and even analyze them with the help of the patient. Alger (1964) suggests that the therapist should "deal with these feelings in no way different than he deals with any other of his reactions. By this is meant that he be willing to include all the reactions he has while he is with his patient as part of the analytic data of that particular situation. ... In this view, the analysis then becomes a joint activity in which two participants attempt by mutual effort to assemble and openly share with each other their perceptions, their concepts, and most importantly their own feelings." Such therapeutic license will call for great skill on the part of therapist, to say nothing of personal courage.

One way of acquiring this skill is to examine oneself honestly rather than defensively when attacked or criticized by a patient. To be sure, it is impossible for a therapist to maintain a consistent

attitude toward or interest in patients at all times. Names and events may be forgotten, indicating to the patient lack of rapport; appointments may be broken or confused, connoting unconcern; irrelevant comments may be made, pointing to "noncaring-ness"; tension and anxiety may be expressed, suggesting instability. Irrespective of the reasons for the therapist's reactions, awareness of what one is doing and willingness to admit one's failings when they are discerned by the patient is of paramount importance. There is nothing so undermining to a patient as to have an observation, predicated on fact, dismissed as fanciful, or to have an obvious error on the part of the therapist converted into a gesture for which the patient is held responsible. Where the therapist is capable of admitting a blunder and of conveying to the patient that this does not vitiate respect and interest, the liability may actually be converted into an asset.

Certain therapists have taken this as license to articulate every aberrant thought and impulse to the patient, and even to act out with the patient. While this may be accepted by some patients as indications of the therapist's genuineness, it is destructive for most patients who expect the therapist to function as a rational authority. Therapists who are basically detached, and who are obsessively preoccupied with neurotic impulses, may, nevertheless, come through to the patient more sincerely as people when they engage in such random and undisciplined behavior than when they assume the straitjacket of a "therapeutic" attitude. From this experience of unrestraint, however, they may devise a theory and formulate methodologies, predicated on being free and abandoned in the therapeutic relationship, a stance that for most professionals will prove to be antitherapeutic.

Detection of countertransference and character distortions may not be possible where deep unconscious needs are pressing. It is this unawareness of their inner drives that so frequently causes therapists to rationalize them. Indeed, the very selection of certain methodologies and kinds of therapeutic practice are often determined by unconscious motivations. Thus, a therapist, basically passive, who fears human contacts and has evolved a detached manner as a defense, may be attuned to schools in which extreme passivity and nondirectiveness are the accepted modes. Or, if by personality domineering and aggressive, a therapist may be inclined toward endorsing the doctrines of those schools that advocate directive or coercive techniques.

MANAGEMENT OF COUNTERTRANSFERENCE

Those aspects of countertransference that reflect the projection of a patient's unconscious process may enable a sensitive therapist to detect unverbalized needs and conflicts. How to deal with countertransferential feelings constructively will depend on how skillful the therapist is in making interpretations and the readiness of the patient to accept such interpretations. It is essential that confirmation of the therapist's intuitive hunches be obtained from other sources of information such as the patient's nonverbal behavior, dreams, slips of speech, free associations, and acting out episodes. The therapist may have to delay interpretations until a strategic time presents itself. The manner in which interpretations are made will also determine how they will be accepted (see Chapter 45).

Some of the patient's actions may stir up realistic angry feelings in the patient that have nothing to do with countertransference. Here it is necessary to judge how propitious a disclosure of such feelings may be. It is sometimes important to verbalize one's angry feelings toward a patient who is behaving in a self-defeating and provocative manner, especially when there is no need to build up a transference neurosis. Such verbalization is not done in a punitive way, but rather as a means of bringing the patient to an awareness of how the patient comes through with people and why reactions toward him or her are less than congenial. Where the patient is in a negative transference toward the therapist or the transference is acting as resistance to therapy, the therapist must control angry feelings and work on the interpretation of the transference to get therapy "back on the tracks."

Since some negative countertransferential reactions are unavoidable, most likely breaking through when the therapist's emotional reserve is taxed or when the therapist is distraught and upset, the question arises as to what one can do to neutralize their antitherapeutic effect. Signs of countertransference include impatience with the length of a session or resentment at having to terminate it, doing special out-of-the-ordinary things for select patients, dreaming about a patient, making opportunities to socialize with the patient, sexual fantasies about the patient, unexplained anger at the patient, boredom with the patient, impulses to act out with the patient, and refusal to terminate when planned goals have been achieved.

In order to become sensitized to one's own neurotic manifestations when they appear, all therapists should subject themselves to self-examination throughout the course of therapy. Such questions as the

following are appropriate:

1. How do I feel about the patient?

2. Do I anticipate seeing the patient?

3. Do I overidentify with, or feel sorry for the patient?

4. Do I feel any resentment or jealousy toward the patient?

5. Do I get extreme pleasure out of seeing the patient?

6. Do I feel bored with the patient?

7. Am I fearful of the patient?

8. Do I want to protect, reject, or punish the patient?

9. Am I impressed by the patient?

Should answers to any of the above point to problems, the therapist may ask why such attitudes and feelings exist. Is the patient doing anything to stir up such feelings? Does the patient resemble anybody the therapist knows or has known, and, if so, are any attitudes being transferred to the patient that are related to another person? What other impulses are being mobilized in the therapist that account for these feelings? What role does the therapist want to play with the patient? Mere verbalization to oneself of answers to these queries, permits of a better control of unreasonable feelings. Cognizance of the fact that one feels angry, displeased, disgusted, irritated, provoked, uninterested, unduly attentive, upset, or overly attracted may suffice to bring these emotions under control. In the event untoward attitudes continue, more self-searching is indicated. Of course, it may be difficult to act accepting, non-critical, and nonjudgmental toward a patient who is provocatively hostile and destructive in attitudes toward people, and who possesses disagreeable traits that the therapist in everyday life would criticize.

The ability to maintain an objective attitude toward the patient does not mean that the therapist will not, on occasion, temporarily dislike many of the things the patient does or says. Indeed, one may become somewhat irritated with any patient on certain occasions, especially when being subjected to a barrage of unjust accusations, criticisms, and demands. The stubborn resistances of the patient to

acquiring insight and to translating insight into action, and the clinging of the patient to attitudes and action patterns that are maladaptive and destructive, will tax the endurance of any therapist, no matter how well integrated one's personality may be. But the capacity to understand one's own feelings will help the therapist better to tolerate the neurotic strivings of the patient and to maintain a working relationship.

To illustrate how a therapist may control countertransference, we may consider the case of a patient who is having an affair with the wife of his best friend and feels exultant about this situation. The therapist, repulsed by the enthusiasm and sexual abandon displayed by the patient, may, therefore, have a temptation to interpret the situation as a disgraceful one, with the object of putting pressure on the patient to give up his paramour. With this in mind, the therapist may enjoin, order, or suggest that the patient stop seeing the woman in question or desist from having sexual relations with her. Should the therapist step in boldly in this way, the interference will probably be resented by the patient. Indeed, transference may be mobilized, the patient regarding the therapist as a cruel, depriving, dangerous mother or father who prohibits sex or freedom. An artificial note will thus be injected into the relationship, the patient utilizing his affair as a means of defying the therapist. Not only will the patient continue in his infatuation, but the therapeutic situation may deteriorate. Or the patient may yield to the therapist's suggestion and give up the relationship with the woman and then become depressed and detached, as if he has been forced to relinquish something precious. He will feel that his independence has been violated.

In attempting to control one's responses, the therapist may indulge in self-searching. Realizing moralistic attitudes, the therapist is better capable of keeping in the forefront the general principle that, right or wrong, the patient is the one who must make the decision about continuing in the affair or giving it up. Accordingly, instead of suggesting to the patient that he stop the illicit relationship, the therapist may say:

"Now here is a situation that seems to have a good deal of value for you. You get fun out of seeing your friend's wife, but you also see that there are difficulties in the situation. Now suppose we discuss the good and bad sides of your predicament." The patient then will verbalize his feelings about the virtues as opposed to the liabilities of his intrigue. Thereupon, the therapist may remark: "Here, you see, there are

values as well as liabilities in the situation. It is important for you to consider all the facts and then decide the course of action you want to take." In this way the therapist strives to keep personal feelings from influencing the patient. The patient is then better equipped to evaluate what is happening and to plan his own course of action.

It is unnecessary for therapists to feel that they must strap themselves into an emotional straitjacket to avoid upsetting the patient. Nor is it essential that they be paragons of personality virtues to do good psychotherapy. As long as one is reasonably flexible, objective, and empathic, and provided that a working relationship exists, one may indulge a variety of spontaneous emotional responses, even some that are neurotically nurtured, without hurting the patient or the therapeutic situation. Actually, the patient will adjust to the therapist's specific personality, if it is sensed that the therapist is a capable, honest, non-hostile person who is interested in helping the patient get well.

For example, a therapist may be inclined to be active and somewhat domineering. The patient may then exhibit toward the therapist the usual attitudes toward domineering and authoritative people: the patient may become fearful, or hostile, or submissive, or detached. As the therapist interprets these reactions without rancor, the patient may challenge the therapist's overbearing manner. The therapist, if not threatened by this stand, will acknowledge the operation of some domineering tendencies. The very fact that the therapist admits responsibility, may give the patient a feeling that he or she is not dealing with the image of imperious authority. The patient may then question the facades and defenses that automatically are employed with authority, and may countenance a new kind of relationship. In working out this aspect of the problem, the patient will undoubtedly see connections with other personality facets and begin working on these also.

If, on the other hand, the therapist acts in a passive, retiring way, basic attitudes toward passive people may emerge. Thus, the same patient may become disappointed, sadistic, or depressed. The therapist, observing such reactions, will be able to bring the patient to an awareness of why these tendencies are being manifested. The patient will learn by this that the therapist is really not an inconsequential person, in spite of a quiet manner. Indeed, the patient may discover personal qualities of need for a godlike authority as well as contempt for any lesser kind of human being. An important aspect of the problem will then be resolved. With this resolution other aspects will come up for consideration,

such as the patient's attitudes toward domineering people. Thus, even though the patient deals with two entirely different reactions on the part of the therapist, basic difficulties will have been managed and hopefully worked out.

What is important, therefore, is not whether the therapist has an impeccable personality that admits no negative countertransference, but rather that prevailing distortions can be sufficiently reduced, controlled, or explicated to provide the patient with a suitable medium in which to work through neurotic patterns.