THE ANALYST'S EMOTIONAL LIFE DURING WORK

Reported by Ruth Aaron, M.D.

The Chairman, Douglass Orr, in his introductory remarks mentioned earlier papers which come to mind on this subject that include: Maxwell Gitelson, "The Emotional Position of the Analyst in the Psychoanalytic Situation", Clark Maloney, "The Analyst Remains Silent", and Anna Maenchen, "Some Remarks on the Psychology of the Analyst."

The first speaker, Marion Tolpin, addressed herself to the subject in the framework of listening to riddles. She sees the analyst's work of understanding his emotional reactions having a facilitating effect on psychoanalytic research. The analyst's mode of experiencing his inner life in the course of work can uncover psychological riddles, shed new light on familiar phenomena and generate new ideas for investigation.

The fact that self observation played the critical role in Freud's work of discovery makes it surprising that self observation is rarely discussed as a data gathering tool.

Tolpin described her study of the unconscious learning process that takes place in some patients during psychoanalytic treatment. Analytic listening to familiar

phenomena can present analysts with psychological riddles which remain to be recognized and solved.

How do patients acquire a capacity for self-analytic work during treatment? Assumptions that future analysts acquire capacities they need to do analytic work by identification with their analysts does not precisely explain the nature of the identification nor of the psychic work necessary to build new ego functions which help form a "work ego".

In Tolpin's work with a patient, she became aware that a particular transference-configuration that fostered the growth of the patient's capacity to understand himself analytically posed a riddle, and that she was unable to solve the riddle until she understood the emotional reactions evoked in her.

During the termination phase of his treatment, he seemed to go on from where the analyst left off in understanding the transference neurosis. A dream gave a clue as to how he used the analysis to do "analytic work without being taught". The patient's experience of the analyst's work of analyzing was an essential part of his experience of the analyst. The dream represented a new

capacity for creative work learned from a gifted famous man. Tolpin was curious as to why he attributed the functions of his work ego to a man, although she was familiar with his transference reaction to her as the admired father imago. Even when his work-dreams were about a woman, she was doing "man's work". There seemed to be an inner necessity to associate the analytic work with the work of a father-imago. This necessity was the riddle. Why was the analytic work as such unconsciously experienced as the work of the idealized father imago of his childhood. The riddle was at first explained away as unique to this patient until there was a similar experience with another patient.

Tolpin realized that her subjective experience with this aspect of the transference was novelty, surprise and curiosity accompanied by forgetting and remembering. This suggested an inner resistance on her part which had to be overcome in order to solve the riddle involved in the structural leap from her analytic function to the patient's own. This signified to her that new insights of general significance can have their beginnings in the

analyst's introspection and understanding of his emotional life in order to understand the patient's.

Tolpin sketched the preconscious routes of her thinking which led to the discovery of the resistance, the overcoming of it in the form of an insight into the clinical data and a new idea about the growth of the analytic function in the transference.

Through the use of her own metaphor by way of the myth of Athene springing from the head of Zeus, she realized the ubiquitous infantile tendency to idealize the parent imago's work roles which was revived in the transference. There is a persistence into adult life of the child's view of the "higher wiser" father in contract to the mother who cares for his bodily and psychological needs. There is also a ubiquitous tendency of analyzable patients to idealize the needed functions of the analyst-mother-father-teacher-model unique to the psychoanalytic situation. She contrasted this form of spontaneous idealization arising within the patient to idealizations fostered by the analyst who succumbs to the temptation to play prophet, savior, or redeemer as discussed by Freud (1923).

Tolpin thus had to understand a "narcissistic blow." Her valued analytic function - work ego and identity

as a woman-analyst was seen by her patient as mental activity belonging to the father whose sole purpose was to teach him, and that for another patient her own valued activity was seen as belonging to him all along.

This understanding of her emotional life broadened her understanding of the analytic imago from whom her patient acquired an analytic function. She further recognized that the patient unconsciously assigned discrete aspects of her analytic workings to an imago perceived as the "mother of intimate mental contact", one who felt with and about his mental experiences. From this imago he learned to take himself as a psychological object in order to be in mental contact with the workings of his own mind.

Tolpin concluded that some aspects of the analyst's intimate mental contact with the patient are a truly new edition of functions which are associated with the maternal imago. This special form of contact has specific consequences for internalization of a capacity to be in touch with oneself analytically.

Thus when an analyst allows himself to be taken

by surprise and does not explain away the inner sense of unfamiliarity associated with a riddle, his emotional reactions can facilitate the recognition of an unusual feature of an otherwise familiar gestalt.

Dr. Tolpin devoted the rest of her discussion to examples of the effect of analytic listening to the unfamiliar on continuing psychoanalytic discovery. She mentioned Winnicott's work on the transitional object and Spitz's with the infant's separation and stranger anxiety, smiling, and yes and no.

Others were Kohut's observations of the narcissistic personality disorders, Benedek's contributions to deeper understanding of female sexuality and Greenacre's significant observations of the very young child's relationship with the father.

Finally, she pointed out that our failures at times to understand our patients and ourselves are a potential route to new ideas as a powerful motive force to self observation which can open up new paths for study. She suggests the notion of a developmental line of an analytic career: A critical stage has been negotiated

when we see that there are riddles in the most familiar of phenomena. Listening can lead to a growth spurt and further development in psychoanalysis.

Dr. O. Eugene Baum gave the next paper addressed to Empathy, Countertransference and the Vicissitudes in an Analyst's personal and professional development. Analysis and self analysis are interminable. Countertransference responses occur no matter how successful the training analysis. A major goal of the training analysis should then be the capacity for self-analysis when countertransference signals appear. Baum's intent was to demonstrate the countertransference occurs inevitably throughout the development of the student analyst, in the graduate and the training analyst. In addition the factor of life stresses that contribute to countertransference must be taken into account.

Since the analyst must be able to feel what the patient feels on the basis of transient trial Identification, he must be able to feel the responses of internalized objects in the patient so as to perceive what is happening in the transference. When the trial identifications break down or do not occur and the patient is used to act out

the analyst's instinctual needs or superego stance, then the analysts' transferences are contaminating the psychoanalytic situation. This is countertransference interference.

Though training analyses are longer generally than patient analyses, that in itself does not eliminate countertransference. Hopefully, a successful personal analysis has sharpened awareness of countertransference signals which can stimulate self-analytic work.

Baum then described some of the vicissitudes of training beginning with the student-analyst starting supervision while still in analysis, a practice which Baum is beginning to question. A student with a difficult patient was unable to actively confront her when it was indicated because of a troublesome counteridentification with the patient and identification with his analyst leading to distortion of the concept of the passive analytic role. At the same time the student was attempting to use his analyst as a second supervisor.

Special problems can arise for the student at the time of termination of his own analysis. A supervisor's

comments may feel as if they apply to the supervisee as well as the patient being discussed. When the student's transferences are being worked on, there may be displacement to the therapy of the patient as well as to supervision.

Case material illustrated these points. A student who came to the supervising hour following his own analytic hour was preoccupied with self and felt a confusion between the two. Another student was totally unaware of counter-transference-interaction with a patient occuring during the termination of his own long analysis.

Baum described similar problems of advanced students who had completed their analyses a year or more. There countertransference reactions had to be in part pointed out to them by members of a study group or an individual supervisor.

With the graduate analyst, there is new found confidence, freedom to experiment with technique, and treatment of different kinds of patients other than the "ideal" neurotic. Greater activity required by different sorts of patients makes the analyst more subject to countertransference responses. This has made Baum wonder about the effectiveness of psychoanalysis in eliminating countertransference even in the very long analyses.

Through the help of study groups and the workshops of the American Psychoanalytic Association, he became aware that many have the same questions and anxieties regardless of the length of analysis. He feels that those who joined faculties and study groups, being increasingly active and identified with psychoanalysis are a recognizable dedicated group. Empathic capacities increased with experience but countertransference difficulties were not eliminated though reduced. Reports of countertransference responses in graduate analysts including training analysts are becoming more common.

Baum and a colleague, by means of a questionaire, undertook a study of the termination of analyses from a clinical point of view. 40% of the cases had residual transference and/or transference neurosis manifestations. An informal faculty meeting to discuss the findings disclosed that countertransference factors were important in the termination of many of these paitents. Among them were the need to hold on in the parent-child model, scarcity of patients, a waiting list, the analysts' goals as opposed to the patients' and realistic goals as opposed to fantasied ones.

There are advantages for one's own psychoanalytic work in being a supervising analyst. Countertransference is readily recognizable in supervision. The teaching-learning situation alerts the supervisor to signals in his own work. This stimulates continued self-analytic work.

The impact of life stresses on the analyst and his work cannot be minimized. The analyst, in the therapeutic alliance utilizing his capacity for regression in the service of the ego uses minimal quantities of neutralized energy. His empathic capabilities depend on this.

If he is preoccupied with his own problem solving, the regression is more like that of the patient and his libido and neutralized energy is bound down in his own problem solving. He may have an unconscious wish for help himself and resent demands made on him. The stage for countertransference is set up.

Baum also expressed the questions he has about the student starting supervision while still in analysis Since the supervisor is identified with the administrative

and judgemental aspects of the Institute, he becomes a focus for externalization of unresolved conflicts. The ongoing analysis lends itself to displacement and split transferences to the supervisor. Separation, mourning and internalization processes have not been completed nor has superego restructuralization. This encourages acting out through one's patient and/or the Institute.

Dr. Baum completed his talk with a word about how the analyst should handle his emotional responses during the analytic hour. He does not believe in sharing these feelings with the patient. When appropriate, with discrete selection and timing, he lets the patient know what it feels like to him as to what the patient is doing to get a response.

In the third paper, Kato van Leeuwen discussed the effect of intercurrent events on the analyst, particularly the impact of all types of interruptions in the analysis and specifically the special situation of pregnancy of the analyst.

She touched on the difficulty of exposing her countertransference as she reviewed her case material

and described the gamut of emotions all analysts experience in their daily work. Along with objectivity, neutrality, warmth and confidence of being helpful, there is irritation when patients cancel, don't pay or act out. Suicidal impulses and violence scare the analyst, and sexual seductiveness can cause discomfort.

The analyst can be bored, flattered, gratified or frustrated by his patients. Maintenance of neutrality under this onslaught is not without cost.

Transference for many years considered an interference, later became the essence of analysis. Van Leeuwen pointed out that while counter-transference used to be considered a contaminant, since the fifties it has been viewed more positively. There is greater emphasis on teaching how to deal with it. She referred to Ticho's and Racker's views on the difficulty of self-examination as the analyst rejects his countertransference and is blocked and defensive. Often only another person can point out the countertransference.

There are differences of opinion among training analysts on how to deal with it in students ranging from leaving it alone as an undesirable contaminant except in extreme circumstances, not dealing with in supervision but

leaving it to the didactic analysis. Others feel it should be part of the training.

Van Leeuwen emphasized the importance of developing a valid approach for the benefit of present and future analysts. Without awareness of all our feelings for our patients, we cannot develop the stamina to be analysts or enjoy our work.

Countertransference, for the purpose of this paper, is confined to the analyst's reaction to the patient as a person of his past and his reaction to the patient's transference, stemming from unresolved infantile conflicts. Intercurrent events in the life of the analyst may magnify conflicts regarding sex and separation in the transference and may be reflected in the countertransference.

A common countertransference problem centers around the patient's reaction to the analyst's absences or vacations. Students need to be taught to look for separation reactions.

Pregnancy of the analyst touches off primitive infantile conflicts in both patient and analyst. It presents realistic and emotional problems to the pregnant analyst. It is essential that colleagues, training analysts

and supervisors understand and recognize their feelings and come to terms with the. Van Leeuwen recalls that some of her colleagues and supervisors were upset with her when she was pregnant, but one sent her a patient. Van Leeuwen felt that her countertransference blocked some of the patient's verbalizations about whether he should be in treatment with a pregnant woman. Many of the patient's feelings centered around attraction to and envy of the pregnant analyst. Not thinking of herself as more attractive or enviable, the transference was incompletely analyzed and he acted out many of his feelings.

With another patient, though she was much more alert to the impact of her pregnancy, she did not sufficiently encourage the patient to verbalize the full extent of his rage, guilt and destructiveness.

Thus, while anticipation and experience are helpful, the analyst needs further ways to deal with countertransference. In retrospect, there had been denial of discomfort in spite of the patients' great rage.

These reflections led to self-analysis and a greater sensitivity to her countertransference. As a result of this she was more keenly in touch with transference manifestations, as illustrated in two clinical examples.

Van Leeuwen, by focusing on her own inner discomfort aroused by the patients' transference was able to evoke

a more meaningful emotional response from a controlling woman patient and bring her into closer contact with an adolescent girl who was very evasive in the transference, resulting in a closer more trusting patient-analyst relationship.

Van Leeuwen concluded her paper by emphasizing the importance of making countertransference part of the supervision and analysis as an instrument to alert ourselves to the patient's transference. It helps the analyst make use of his feelings rather than fight them. As the analyst focuses on his emotion, he or she may uncover nuclear conflicts in both patient and analyst. Access to defenses can be facilitated by using these reactions deliberately towards verbalizing what was previously preconscious or unconscious.

In the final paper, Ralph Greenson talked about loving, hating and indifference toward the patient. He defines countertransference as a transference reaction in an analyst toward his patient thus being a distorted and inappropriate response derived from unconscious unresolved conflicts of the analyst's past. Regarding all of the analyst's reactions to the patient as countertransference negates the value of the real relationship essential for sustained collaborative work.

Limiting the term countertransference to the analyst's response to the patient's transference limits the meaning. The analyst's transference reactions to his patient subsumed under countertransference should also include his reactions to people close to the patient.

Greenson illustrated this point with a clinical example in which he became openly angry at a patient's doctor as she described the doctor's refusal to make a night visit to see the patient's sick child. He felt that his reaction was inappropriate and that it was a counter-transference response to the patient's predicament, not her transference to him.

In another clinical vignette, he described his interaction with a patient which ran the gamut from counter-transference to non-countertransference. A nagging, complaining woman remarked that she was no pleasure to work with. A hostile sarcastic rejoinder flashed through his mind which he controlled, but it put him in touch with the intensity of his negative feelings. He than acknowledged to her, how difficult she was, a confrontation which shocked the patient into new awareness. There were countertrans-ference and realistic aspects to his rejoinder which were useful to the patient. Later, in thinking about the hour,

he thought of a remark that would have been controlled and realistic.

Greenson went on to describe the much greater dangers of the countertransference neurosis which can lead to sexual acting out, or making an opponent out of the patient. Equally important is the necessity to recognize/the that analyst's narcissistic needs contribute to countertransference as well as his instinctual needs and defenses.

The analyst's daily experience of tolerating the patient's loving and hateful feelings and responding to them analytically is a constant strain. If problems in the analyst's personal life occur at the same time, the extra burden can make him susceptible to counter-transference. Sometimes the best way to deal with such a situation is to cancel appointments for a few days.

The working alliance in the analyst is analogous to it in the patient and just as essential. Strong counter-transference feelings whether negative or positive can interfere with the working alliance and lead to adverse developments in the analysis.

Empathy is most reliable when motivated by the working alliance. If countertransference is stirred up

by empathic contact it must be put at the service of the working alliance to be effective, otherwise it can lead to a loss of empathy resulting in errors in interpretation.

Countertransference reactions if detected and controlled can make a positive contribution to the therapeutic process. The analyst must be alert to discover it in himself by constantly monitoring his thoughts, feelings and impulses. If they are present, are they appropriate to the material? If they are not, why not. Too much love, or indifference, frequent dreams about the patient, forgetting of appointments, sleepiness or boredom are warning signals.

Greenson listed technical steps in dealing with countertransference. There must be a readiness and vigilance to look for countertransference responses. This can alert the analyst to look for the stimulus in the patients' responses. By introspection and free association the analyst can explore the unconcsious source of his countertransference and his unconcsious motives for hurting or helping the patient. Unnecessary hurtfulnes, should be acknowledged to the patient but not its

unconscious source. The help of a colleague may facilitate self analysis.

Greenson ended his paper by emphasizing the constructive potential of the countertransference. While it may be the source of serious obstacles it can be of great value for the analyst's understanding the patients' neuroses.

In the discussion amongst panel members following the papers, Orr said that the material represented "things my analyst never told me - as far as I can remember". Analysis can be a tax on one's character as well as one's neurosis. For example, an aggressive character is impatient with a dawdling patient. There is the feeling of a wasted hour.

Ruth Aaron said, that, as recorder, she was interested in the transference and countertransference feelings aroused in meetings as one watches and listens to one's colleagues, peers and teachers. Envy, boredom, idealization and intellectual stimulation can inspire desires to withdraw, criticize, compete or extend one's curiosity and pursuit of knowledge.

Dr. Baum commenting on Dr. Van Leeuwen's paper, wondered about aspects of the real relationship in response to the analyst's pregnancy which stimulated fantasies. Was there denial of sexual exposure? Was there a negative transference to the child in terms of sibling rivalry, and how much libido was available for the analyst's work.

He questioned Greenson's use of the term countertransference in every instance. In the first clinical vignette, he wondered if Greenson's reaction was necessarily countertransference. Perhaps it was a characterological stance. Feelings toward patients' families perhaps don't come under the term. Any feelings going beyond empathy contaminates the analytic situation.

Greenson reminded that self analysis is interminable and countertransference is so strong. A listener is valuable. He wasn't taught. He learned on his own. He also disagrees that all emotional response is countertransference. A low key affective response, only, is an impossible way to conduct psychoanalysis.

Dr. Tolpin felt that the term counter transference was too all inclusive. The analyst as his own instrument

uses empathy. How he understands his patient's productions and then puts his knowing into secondary process for the patients has not been fully integrated into psychoanalysis. Fenichel said that anyone blocked in work he likes, feels annoyed. There are average expectable experiences in psychoanalysis. Their absence is bizarre. Boredom, anxiety, etc., are triggers to the analyst's tool of self awareness preparing him for his next step.

Dr. Van Leeuwen noted the enrichment gained from a panel discussion. A child analyst has more difficulty in using the element of "surprise" because of the child's instinctual life: The analyst like the patient suffers from repression of some childhood experiences like separation because of parental interdictions. The pregnant analyst thinks that patients may not notice. She may think of herself as flat like a man. Involvement with the expected child may be experienced as preventing carrying out her involvement with the patient and provide an area of conflict for her. Sometimes the training analyst believes that the pregnant candidate is acting out a resistance.

Contributions from the audience included Walter Briehl's recalling Franz Alexander saying to a dirty patient, "you stink." The patient answered, "Now I know that you are honest."

Roger Shapiro pointed out a theory of therapy and its relationship to countertransference such as the defense concept of analyst as mirror. One is alone in self analysis. We fear censure by colleagues.

He respected Dr. Tolpin's honesty. She focused on how she used her surprise to concpetualize and understand. How does one work with a patient following one's new discoveries. We need a theoretical framework to understand countertransference.

Merton Gill agreed with the panel's major position that countertransference is not a sin. It is inevitable and can be turned to good use. There must be a transference neurosis to have an analysis. It begins with the patient's involvement with the analysis and the analyst. The same is true of countertransference, perhaps the analysis of a "countertransference neurosis" is essential to an analysis. Involvement is necessary in both instances.

In commenting on Greenson's paper, Dr. Gill felt that the lady of the first vignette must have provoked something in the analyst necessitating his proving he was a caring doctor. Greenson had said that it is often important to find the reality stimulus from a patient which provokes countertransference. Gill said

the word should not be "often" but "always". In connection with the second clinical example, Gill noted that we must pay more attention to what the patient thinks we think about him. It should be picked up as early as possible, but he isn't sure why.

There are temperamental differences among analysts. It may not be true that all analysis should be conducted on a neutral plane. The analyst must feel nurturance and hate for his patient. Perhaps every analyst must develop a countertransference neurosis toward his patients.

John Livingston asked if Dr. Greenson recommended periodic re-analysis since countertransference is unconscious.

Jerome Karasic referred to the shame and guilt about countertransference. Greenson's examples were not painfully revealing. Freud submitted only parts of his dreams.

Dr. Greenson felt that Dr. Gill's revolutionary conclusion that a countertransference neurosis is essential may be true, but he would have to think about it. Jones tried to explain Freud's omission of his countertransference as protecting his famous patients. We do not have that problem.

Orr reflected the attitude of panel and audience to the subject matter by remarking on its fascination and hope that it can be further studied.