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Countertransference Manifestations, Situational Factors, and Intercurrent Events in the Life of the Analyst.

"The analyst's emotional life during work."

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Out of the many facets of the rich emotional life of the analyst during work, I choose to focus on events and situations likely to ripple the surface of the reflecting mirror so often judged the ideal state of the analyst's mind. The admirable qualities of the analyst -- warmth, acceptance, empathy, neutrality, objectivity, the ability to maintain an effective distance and giving the patient the feeling he can help -- do not necessarily imply that the analyst does not experience emotions. On the contrary, the analyst's effectivity depends on how he uses his feelings. Analysts react with irritation when a patient is late, cancels, does not pay the bill, acts out, becomes pregnant, drunk or gets into trouble. Suicidal impulses and violence scare the analyst, sexual seductiveness makes him or her uncomfortable. The analyst becomes bored when the patient talks in a monotone, and perks up when the patient reveals information about a subject that interests him, or information about someone he knows. He is gratified when the patient makes progress, is productive in the

analyses, ~~and~~ more successful in his personal life, and expresses admiration of ~~his~~ the analyst's therapeutic skill; he is irritated when the patient criticizes. He empathizes, represses his wish to advise, and instead helps the patient to analyze his feelings. The analyst may be uncomfortable with a richer, more famous patient or one of a different race, religion, or cultural background. (Calnek, 1970 Schachter and Fisher 1971 ± Butts 1968 Sherman 1973)

How do analysts maintain neutrality under the onslaught of feelings with which they are bombarded every working hour? Do they sit there helplessly taking it all? At what cost do they remain objective? Every analyst deals with this problem differently yet they have much in common. To what extent does the analyst call on his mechanisms of defense?

Transference, for many years considered an interference, later became the essence of analysis. Freud (1917) emphasized the importance of understanding the defenses stemming from transference to the analyst and the need to show them to the patient, to interpret, to discover, to communicate. He emphasized that these defenses are analyzable because they are part of the ego rather than of the unconscious. Does the same hold true of countertransference? Self-examination (Ticho, 1967) is difficult as the analyst rejects his own countertransference (Racker 1957). The analyst is blocked, narcissistic, and defensive. For

this reason didactic analysis was made part of analytic training. Yet blind spots block any analyst's skills, no matter how long his analysis.

Quick to detect countertransference in our colleagues we tend to deny it in ourselves. A systematic attempt by the Menninger Foundation (Luborsky, et al,) showed how difficult it is to discern countertransference even from a tremendous amount of information. Supervisors had some clues, but only when it obtruded in a form detrimental to therapy. Alexander (unpublished) had the therapist press a button when he had a feeling during an observed therapeutic session. This would prevent some reactions from being forgotten, but did not reveal what occurred outside the therapist's awareness. Bergman (1966) recorded introspectives after a therapeutic session and found that countertransferences often need to be pointed out by a third person. The therapists view of a transaction in psychotherapy differs markedly from the view of the patient or an outside observer as demonstrated by the "triple view" study of Auerbach (in preparation) probably because of countertransference. Though countertransference dominates the discussion amongst supervisors (Kaiser '56 on a panel headed by Windholz on supervision), it is not necessarily examined.

Training analysts' attitudes towards countertransference vary. Many feel that it should be left alone except in extreme circumstances (Lebovici, 1970).

Disapproval is often expressed of confrontation of the supervisee with countertransference (Szurek) since it properly belongs with the training analyst. ~~This~~ These differences points up the need to develop a better approach lest we deprive ourselves and our future colleagues of a valuable and necessary armamentary. Without feelings for our patients, without sublimated sexual curiosity, without vicariously enjoyed participation in someone elses life, we would neither be analysts nor enjoy our work. We need to develop ways of using these qualities for maximum skill in analyzing our patients.

In order to examine these questions, I selected areas which tend to magnify and intensify the analyst's infantile neurosis and its defenses against it. Berman's (1949) concept of countertransference as the analyst's reaction to the patient as an important person of the past seems most applicable. I postulate that both the patient and the analyst tend to be troubled by the same nuclear problems and that countertransference in the analyst is the counterpart of transference in the patient. Since reactions to intercurrent events in the life of the analyst tend to point up, sex and separation, nuclear problems in the transference ~~(van Leeuwen, Hannet, _____)~~, these same situations might be reflected in the analyst's countertransference.

My turning to current events and situational aspects serves merely as a means to facilitate my own focusing on

countertransference in an attempt to explore what it is all about by focusing on an area I have found previously useful in examining nuclear conflicts. Not many papers have been written on the effect of intercurrent events in the life of the analyst. Fromm-Reichman warns to neither overestimate nor avoid the patient's reaction to events in the analyst's life and to let them know when you feel it interferes with the analysis. Patients should be given credit for their ability to discern and be helped to verbalize their observations. However, patients may be so preoccupied with their own troubles that they pay no attention to what occurs with the analyst

Out of the many intercurrent events in the life of the analyst: illness, divorce, meeting members of the analyst's family, financial difficulties, vacations, changes of office location, appointment times or costs, I will select the frequently denied seemingly minor reactions of the analyst to interruptions (van Leeuwen and Pomer 1969) and the, not as easily glossed over, reactions to pregnancy. Pregnancy presents realistic and emotional problems to the pregnant woman analyst; the male analyst is also confronted with his own primitive feelings when his wife or patient are pregnant or a colleague he sees in supervision. Hannett (1949), van Leeuwen (1966) and Le Bow (1963) refers to the depth of feelings in the transference in response to pregnancy of the analyst or a

miscarriage. Jackel (1966) reported pregnancy fantasies of patients in response to absences; and Weiss (1972), to the intensification of the transference when he announced the move of his office to another town. Only Ruth Lax (1949) specifically focused on countertransference feelings of the pregnant analyst pointing out such major areas as the anticipated discomfort of the patient's discovery of the pregnancy, fear of hostility and attack, being oblivious to allusions by male patients or thinking they did not notice the pregnancy, and guilt feelings resulting in excessive concern for patients. All these reactions appeared to be related to unresolved infantile conflicts within the analyst delaying verbalization of the patient's reactions to the analyst's pregnancy.

Let us first examine countertransference reactions to separations. Though we experience feelings of irritation when the patient changes an appointment or threatens to terminate the analysis, we tend to rationalize the changes we make unless we have been taught to look for them. Fryling-Schroeder (1970) points out that nearly every associate needs help with his reactions to interruptions in his first analytic case.

Thus, Dr. F. failed to perceive how his repeated manipulations of appointment times, financial arrangements and location were reflected in the patient's associations. The

patient who dealt with her anxiety about being a woman by being controlling reported a dream in which she was unable to compete with a mother figure and then recalled her father's leaving her after treating her to an ice cream cone. Repeated effort to demonstrate that the patient's feelings in the transference were related to Dr. F's giving her extra time because he expected to miss several appointments, met with considerable resistance and continued ~~familiar~~ similar behavior. Upon expressing amazement that Dr. F. failed to see the connection, it became apparent that Dr. F. rationalized the reason for his absence; it was legitimate and professional rather than for pleasure. Therefore there was no reason for this woman to be upset. Following verbalization of previously repressed guilt over being manipulat~~or~~ive and anger over her the patient's failure to comply to the change, Dr. F. became more cognizant of the effects of his actions and more able to help the patient verbalize her feelings of being controlled and seduced by him, and the analysis proceeded

Not being defensive about her move of offices, Dr. M. who already had some analytic experience, utilized her patient's surprising reaction to the move of her office to better understand the patient's feelings. Rather than pleasure over the more convenient location and roomier quarters, the patient resented and feared the consequences. Exploration of the patient's turmoil revealed fierce

competition with a younger, better loved brother. The move was experienced as a recurrence of her feeling neglected in favor of someone else. Focus on her reaction to the move and other interruptions brought her fears in the transference into the open and facilitated further analysis. If Dr. M. would have been defensive and had resented the patient's lack of delight, or felt guilty about what she did to the patient, she would not have been able to deal with it in this fruitful manner.

A dignified university professor reacted to the first interruption of the analysis with a dream of breaking dishes. Astonished at the strength of these feelings which he thought most unbecoming and infantile, he was able to relate them to angry feelings at his mother at the time of the births of his younger brothers. The analyst, DR. B., was aware that her patient's feelings were related to X-mas vacation coming up and that he now had these feelings towards her because she was leaving him like his mother to his own devices. The breakthrough of the patient's intellectual defenses could perhaps have been utilized even more fully by asking him to verbalize why he thought he reacted so excessively. This might have facilitated putting this obsessive-compulsive man in touch with his expectations to be cared for in the present, by the analyst and his wife. Why was not the analyst as surprised as the

patient at this sudden outburst of anger? Do analysts tend to intellectualize and thus further intellectualize-ation in their patients? Was Dr. B. warding off similar infantile feelings in her past? Should we be content with knowing past reasons for behavior without fully exploring what precipitated them in the present, what the patient's expectations are of the analyst as a person? Did the analyst perhaps identify with the patient, thought she understood fully how he would feel and therefore missed the opportunity to explore?

Throughout the analysis of an adolescent girl, Dr. H. had been aware of a certain slipperyness and an indefiniteness difficult to analyze. Towards the end of the analysis, the patient again began to put obstacles in the way of her success and once more came late for her analytic hour. Dr. H., while waiting for her, began to examine his feelings about this. He felt impatient and annoyed at her regressive behavior, yet welcomed having a few extra minutes. When he heard the patient enter the waiting room, he experienced a sense of relief. At least the patient had come and it was possible to find out what was going on. The situation was not totally frustrating. The patient bounced in, commented on her lateness (repeatedly examined in the past), and added that this time she had a good reason. She overslept. This led into more intensive investigation of what this meant to her. She was late everywhere, not just

for her analytic hour. She did not really care. When she felt good, she was overly conscientious and hated it. Now she had become successful in school ~~and~~ she tended to time it so that she would be just a few minutes late, enough so the teacher would notice but not necessarily long enough to be justified in failing her. She was aware of damaging her chances for success. Dr. H. recalling his irritation about the lateness offered that though she pretended to herself that she hurt only herself, maybe she ~~decided~~ denied what she tried to show him and the teacher. The patient reacted with astonishment, then corroborated the truth of the statement. She had always told herself that she had to rely on herself, that neither her parents nor her analyst offered anything she needed. She could only count on herself or hurt herself. Losing the analyst would not be a loss as she never counted on his support. Now she saw how by being a "super" person she defied and hurt the analyst, her teachers, and parents. This episode demonstrated why she had ~~fought~~ avoided real involvement in and outside of the analysis. Did Dr. H's focus on counter-transference sensitize him to what happened in the transference opening up the most bothersome aspect of the analysis and bringing him in closer personal contact with the elusive patient? Did Dr. H's awareness of his feelings just before her entrance remove his defenses against involvement with the patient providing a tool for exploration of the transference?

The above discussed situations are all related to countertransference reactions to interruptions of the analysis from vacations to being late. Is it difficult for the analyst to recognize in the patient what he had to repress as a child in relation to his parents, namely, his feelings about their absences, feelings which were neither convenient nor acceptable (~~van Leeuwen and Pomer~~ ——). What happens when the analyst is aware that he is going to react but does not know just how to deal with these uncomfortable feelings?

I want to examine countertransference reactions to pregnancy in the analyst as this too provokes a host of primitive, infantile conflicts in both the patient and the analyst. Unless the training or supervisory analyst understands his countertransference reactions, he will not adequately analyze his patient or help the pregnant supervisee or analyzand understand her countertransference. As one training analyst revealed several years after termination, he experienced the analyzand's pregnancy as a resistance, thought of her as brazenly flaunting her sexuality. He realized that he had repressed his envy of her sexual freedom and thought of her as a prostitute. Thus he failed to analyze her attitude towards her pregnancy. He analyzed her as if she were not pregnant, reenforcing her denial of her need for special medical care and consideration. Similarly, supervising a pregnant associate my be difficult because of inability of the supervisor to cope with his hostility, admiration, or envy.

A patient referred because of his critical attitude towards women resulting in disruption of his marriage, bitterly complained about the noises of young children in his quarters. Dr. R., 6 weeks pregnant, correctly perceived this as related to her pregnancy but since she was not sure and was afraid to misinterpret his associations said nothing. Several weeks later it became even more obvious that he suspected that she was pregnant. Dr. R. readily accepted his rationalization that he considered the experience of being analyzed by a pregnant woman a unique and ~~an~~ excellent opportunity to come to terms with his feelings about women. The patient was interesting and Dr. R. did not want to lose him. Dr. R. protected herself against the patient's anticipated rage about being deserted, by giving him extra time on occasion. Though the analysis progressed the analyst's countertransference blocked verbalization of the patient's question whether he should be in analysis with a pregnant woman and what it meant to him. Though sexual and destructive feelings surfaced repeatedly and were interpreted, their full intensity was neither perceived by the analyst nor the patient. This resulted in them being acted out. The patient searched for a better mothering woman, flitting from flower to flower, pollenating, and indeed, while the analyst had a baby, he succeeded in impregnating his estranged wife followed by abortion.

Alerted to the impact of pregnancy on the patient, Dr. R. carefully analyzed the reactions of a subsequent patient. Upon perceiving that Dr. R. was pregnant, the patient alternated between wanting to be the father of the baby, being the baby, and being a woman giving birth himself. His feelings became so intolerable that he temporarily quit analysis and only with great difficulty was persuaded to return. He tended his cat, adopted a wild goat, and dreamed of planting orange seeds from which grew a giant orange. Though Dr. R. was alert to the impact of her pregnancy, she did not permit the patient to sufficiently verbalize the ~~tremendous~~ rage he felt towards her and his mother ~~and~~, his inability to face the tremendous destructiveness ~~which~~ also came through in the necrophilic aspects of his profession and guilt over his wish to explore and destroy the inside of his mother's and analyst's body. Nevertheless he worked through his feelings sufficiently well to replace the analyst with a better mothering woman and got married soon before the analyst had her baby.

Thus it is apparent that anticipation and experience are helpful yet the analyst needs further tools to deal with countertransference. Upon rereading her notes, Dr. R. was struck by the tremendous rage these patients had expressed, and her failure to deal with them in a more personal way. She suddenly realized that her own impotent

rage at her mother's pregnancies had never been completely analyzed. She surmised that she protected herself and the baby by defending herself against these painful insights.

A shy young girl unable to make and maintain satisfactory relationships with men or for that matter with women was a very boring patient. She reacted very little when in the third year of analysis the analyst became pregnant. However, when the analyst had a miscarriage, this patient come to life. She expressed a great deal of envy and many sexual fantasies and fears of destroying the analyst's baby by looking. Her previous dullness had been due to repressed anger towards the analyst and her own parents and their relationship from which she felt excluded. Her depression lifted and she began to make a more satisfactory social adjustment.

There are several things the analyst should have been more cognizant of. First of all, her discomfort about the patient's failure to react to her pregnancy should have tipped her off that the patient was holding back. Unconsciously it might have been more comfortable for the analyst to deny her own sibling rivalry and thus help the patient repress hers.

A man in analysis reacted with glee when his analyst had a miscarriage and his enthusiasm was only barely concealed. He dreamed of wetting the couch happily. The analyst found

it almost impossible to help him analyze his triumph because his feelings were so discordant with her sorrow.

A young girl selected her analyst because of her sexual attraction to him. When she was finally able to reveal her sexual excitement in his presence and how she felt that she never could be desirable to him, D.S.Y. ~~he~~ felt uncomfortable and did not know what to say. The reasons for these transference feelings were not analyzed. She forced him to pay attention to her by acting out these fantasies with a young man. The question of pregnancy came up. ~~It shook~~ the analyst felt devastated as if it was his fault that he had not analyzed her fantasies and he feared that if it were true, that she was pregnant her parents would disrupt the analysis.

I will now give several examples of what may happen when the analyst makes a conscious attempt to be in touch with his feelings. A asthmatic young woman (who came to treatment because of severe ambivalence about her pregnancy), in her third year of treatment was startled when the analyst entered the waiting room and asked her not to smoke. She quickly extinguished her cigarette, entered the room, and asked if the analyst knew of the note in the waiting room. It quickly became apparent that she concluded that the note was directed to another patient and that she reacted to the fact that this patient was called by her first name while she, a married woman, had to act mature and be

called mrs. She then expressed criticism of her husband's analyst who got her husband up too early and who criticized him for discussing the analysis with her. The analyst felt vaguely uncomfortable about having left the note and the abruptness of the no smoking request. Not having been a good parent protecting her patient from sibling rivalry, she had scolded the patient. The analyst deliberately focusing on the inner discomfort, then asked the patient if her feelings about her husband's analyst were related to the note and the smoking. Not mentioning the prohibition of the smoking the patient then ~~she~~ revealed much more intimate material about her wish to be very special, her machinations to achieve this by dressing stunningly, having a brilliant husband, and associating with important people. She had decided to outdo the analyst by not talking about cigarettes as she was sure the analyst wanted her to. She attempted to control her husband by concealing information and by telling her husband suitable fragments of the analysis. Thus the analyst used her own discomfort and got a much more emotional response from this ingratiating patient who was loathe to expose competitive feelings with the analyst.

Discussion

Not only should analysts be cognizant of their feelings towards their patients, they need to develop techniques of utilizing countertransference to become more effective analysts, thus turning evil into virtue.

To be more effective it is essential for analysts to be in touch with their reactions to patient's transference. Supervisors and training analysts instead of avoiding these issues should seek them out and develop techniques of dealing with them.

Analysts tend to defend themselves against uncomfortable feelings. Reactions to situational factors as displayed and by the quest of the pregnant analyst serve as examples pointing up major countertransference aspects. Reactions to interruptions can be used to unearth major nuclear conflicts. The reason that some analysts are not aware of these feelings in either the patient or themselves goes back to the fact that it has been necessary in the past to repress these reactions, very much the same way parents are inconvenienced by their children's protest or sadness. Both parents and children conspire to hide what they feel. Thus the analyst reacts to the patient, not hearing their cry nor perceiving their plight as his parent did not seem to hear his. The similarities to the way observations of pregnancy are treated by both the adult and child are obvious. Both parent and child

conspire in not seeing. The analyst reacts as if the patient had not observed the changes in her mother's body or his knowledge of what goes on between his parents.

As it is important for parents to help children verbalize their feelings, it is crucial for the analysis that the patient understands his reactions in the transference. Only if the analyst uses his own discomfort to be alerted to his patient's feelings does he gain access to the transference. The patient does not necessarily react to what the analyst thinks he reacts to as we all tend to project, however the analyst will try to find out if he uses his discomfort as an instrument. This should become part of the analytic process. Thus this knowledge of typical reactions to intercurrent events may be applied universally, not because people all react the same way but because certain stresses are ubiquitous.

Summary

It is practical, rewarding and maybe imperative to closely examine the analyst's feelings about his patients. Current events and situational factors are used here to point up how the analyst deals with his emotions during work. They are omnipresent. We can deliberately focus on them; they may lead to uncovering nuclear conflicts in patient and analyst. Access to defenses can be facilitated by using these reactions consciously towards gaining access to the unconscious.