PERSPECTIVES ON TECHNIQUE
ASPECTS OF COUNTERTRANSFERENCE

by

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One of our goals as analysts is to help our patients speak better about themselves—more honestly, with more awareness and less amnesia, and with usable insight. And, of course, we as analysts can also entertain such goals for ourselves, particularly in describing what we do and in our self-understanding of why we do it. With such an ideal in mind, I would like to discuss a topic which has received much publication in the last few years but which still seems to generate confusion among analytic students. The topic I have in mind is countertransference.

There are, it seems to me, three broad areas of interaction which have to be recognized as operative within the analytic setting. First, there is the patient's transference, classically articulated in Freud's writings and in analytic literature; second, there may be the analyst's transference to the patient; and, third, there are those non-neurotic responses which arise out of the respective character structures of either the patient and/or the analyst as well as any induced responses in the analyst by the patient or in the patient by the analyst. This third area is particularly important for those patients who come to us still putting together the building blocks of the self, as it were. If the analyst is to help these patients, he must be able to distinguish his interventions from any possible countertransference.

The term countertransference should be limited in its meaning, I believe, to the second alternative mentioned above; namely, an unconscious transference reaction to the patient. Like transference, it is rooted in the analyst's past and signifies the activation of neurotic responses inappropriate to the present situation. Countertransferential reactions may be recognized directly by means of discussing a case with a colleague, for example, or within the therapist's own analysis, or, indirectly, when the treatment stalls for no apparent or discoverable reason. A "good enough" training analysis should significantly lessen the possibility of countertransferential reactions. It is in this context that we can appreciate D. W. Winnicott's remark that countertransference is anything which interferes with the professional stance of the analyst to the patient. And professionalism does not mean ideological orthodoxy; rather, it entails a good mixture of integrity and intelligence, of mastered competence and felt compassion.

Given our discussion so far, I hope it is clear why such expressions as the usefulness for the patient's treatment of the analyst's own countertransferential reactions become quite meaningless. If the analyst becomes aware of and works through any countertransferential reaction, it will help him know himself more but will not directly help the patient. What can be useful, and what seems frequently to be confused with countertransferential manifestations are all those interventions based on the patient's developmental needs in putting together a self. By way of some general examples, a patient's narcissistic arrogance may require both a caring response as well as an angry response on the part of the analyst. Or, for the patient who may need to hate the analyst for a while, the analyst must help set limits to the hatred and set a mode for its expression but ideally not hinder its emergence, particularly by use of genetic interpretations. Patients suffering from paranoid grandiosity are liable to induce some anxiety and self-protective feelings in the analyst, and persons who have early damage to their core self may easily induce mothering fantasies in an analyst. Such responses on the analyst's side do not indicate automatically, in the meaning of the terms I am using, countertransferential phenomena. They must, of course, be understood and used therapeutically by the analyst, but the point
bears repeating. Countertransference is not the analyst's (counter) response to the patient's transference or character structure. It is the analyst's own transference response to a given analytic situation. It may be triggered by the patient's transference or character structure, but it is essentially the unsolicited static the analyst brings to the treatment of a particular patient or, sometimes, to all of his or her patients.

First, below I will discuss countertransference. In my next column I will discuss analyst responses to developmental needs and induced feelings.

A few years ago a therapist came to me for supervision; it was a relatively short exposure since she stayed for thirty sessions only. She was a bright, personable student, in her mid-thirties, unmarried, who had done therapy for a number of years in a clinic setting and was starting her own practice. She had begun with another supervisor but had abruptly broken off after three sessions before coming to me. When I asked why she had stopped seeing him, she said she had had some negative reactions to something he had said, that it was just terrible, and that she had discussed it with her analyst. She was clearly unwilling to discuss the incident in detail and, given the nature of our relationship, I did not pursue the matter. Two points became clear as she discussed a few of her patients: one was her intellectual ability to grasp at least the essential therapeutic issues at hand, and the other was her inability to effectively focus this knowledge in terms of any therapeutic interventions. Often at a point where an interpretation or intervention would have been indicated, she would go on to a different topic with a patient, or sit silent. When this pattern was pointed out to her, she repeatedly asked that I continue to show it to her and help her to understand what she might be doing to cause this. In one case (she spoke mainly of two or three cases), it seemed to me that she was involved with some management issues and would have to employ other than classic techniques to reach the patient. When this was indicated, she spoke about how difficult it was for her to do differently than her analyst had done with her and added that she knew she could never be a psychoanalyst like him and hoped, at least, to be a decent therapist. On first hearing this, I thought it was the modest anxiety of a beginning student and, since I was not sure whether or not her reactions were limited to the cases she had presented, I asked her to discuss all the patients she was seeing.

She came in week after week with some, but rather limited movement in her cases, and she herself was aware of a kind of low grade stagnation which seemed to be present. I do not mean to suggest that this student was totally inept, for she clearly was not. Besides her good mind, she had the capacity for empathy for those persons she was seeing. As supervisors know, a student's possible countertransference can be a sensitive issue to deal with in the beginning phase of one's work. One must avoid a narcissistic injury to the student as well as interfering with the student's own treatment. In the present case, it seemed to be the very exercise of her private practice which was evoking some kind of diffused countertransference that hindered her in applying what she knew. Since this student seemed so candid, I asked her if she had discussed some of the difficulty she was experiencing with her patients with her analyst. She said she had but added that she still had a good deal of oedipal material yet to work out. (It was clear also that the differences between her analyst's and my technical interventions clearly bothered her.) She spoke of the effort she had put into her analysis by saying that she was in treatment four times a week and had been seeing her present analyst on such a basis for about fifteen years.

In the next few sessions after this, we spoke again of the difficulty she had in effectively interacting with her patients and she added that she knew she would never be a real depth psychoanalyst. I then spoke to her about the possibility that her prolonged analytic relationship in itself might be producing possible side effects, perhaps some intimidation and/or lack of feeling for herself as an independent practitioner which might account for why she could not be more effective with her patients. I said that it would be helpful to discuss this possibility with her analyst to see if this might be an issue or not.
Starting her own private practice had apparently triggered off a generalized response to her patients perhaps because of a primitive idealization of her own analyst with a consequent inability to tolerate anything which might threaten this idealized figure.

I can presume however, that I spoke too soon since she stopped her supervision the next week saying she could not afford it anymore. I had focused, even as gentle as I tried to be, on an area which was in temporary eclipse for this therapist. Counter-transferences, of this kind, are difficult for any therapist experienced or not to catch, for they are not singular or dramatic.

The ethics of psychoanalysis are not so much measured by external conduct as by a relentless internal honesty which avoids superego judgment. The resolution of a patient's transference, after the initial discovery aspects are passed is very much linked I believe to a patient's internal willingness to see his part in supporting the transference. Such honesty does not come easily to human beings and, of course, this was the 'sin' Freud committed—not discovering the unconscious when he confirmed and reminded us of our self-deception. A patient has to face this issue during his/her own analysis; we, of course, as analysts must face it many times over. What was laid to rest in our own training analysis may easily be called back to life in working with our patients. What we must bring to ourselves is what we bring to our patients—integrity, intelligence, competence and, of course, compassion.

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LETTERS TO THE EDITOR

Editor: NEWS AND REVIEWS:

Thank you and your committee for arranging the service of workshops (Jan. 13-14) with Dr. Schafer. Dr. Schafer would not agree that he made me think; he would kindly, patiently, and skillfully help me to see that I made me think, which, as I think about it, is much more gratifying to me. However, using metaphorical language with which I am more comfortable (and which Dr. Schafer would agree I should continue to use, at least with my