

COUNTERTRANSFERENCE: THE PSYCHOANALYST'S SHARED EXPERIENCE AND INQUIRY WITH HIS PATIENT

BENJAMIN WOLSTEIN

*2 West 67 Street
New York, New York 10023*

From all that has been said about countertransference during the last 70 years, I have selected for discussion a theme that has not received the full attention it deserves; that of countertransference as part of a field of experience and inquiry, belonging as much to that field for shared experience and inquiry as, for example, the patient's transference. And this, of course, applies not only to countertransference but also to counterresistance and counteranxiety, not only to transference but also to resistance and anxiety.

I do not mean to refer only to the psychic symmetry of the psychoanalyst and his patient as two human beings in therapeutic relation to each other, but, more importantly, to indicate that psychoanalytic therapy does, in fact, take place precisely because the two coparticipants can treat transference and countertransference within a coequal frame of reference and within a shared field of experience and inquiry.

The principle that their relatedness is symmetrical rather than coordinate, or that their frame of reference is coequal rather than hierarchical, derives from some relevant social and cultural philosophies of our time, especially for those psychoanalysts and patients who believe systems of value rooted in humanism, science and democracy, such values as individuality, truth and freedom.

But the principle of psychic symmetry in psychoanalysis, however, does not express a mere preference in social and cultural philosophy. It reflects, instead, the unity underlying all psychic process. It points up the essential condition of the human psyche,

whoever possesses it, in whatever environment of biology and geography, history and sociology, beliefs and values, as simply human psyche striving to realize itself.

Since the psychic data of psychoanalysis are investigated by the methods of direct psychological inquiry, they remain, by the same token, symmetrical data. From this principle we derive, in addition, the clinical theorem that countertransference, as psychic experience undergone during psychoanalytic therapy, is no different from transference, or from other psychic processes and patterns of any two coparticipants in psychoanalytic therapy.

The important clinical application of this principle of psychic symmetry is that the psychoanalyst cannot ascribe to himself special status for his social or ego-interpersonal role with his patient. Nor can he claim it by virtue of the symbols of power and prestige ordinarily ascribed to his expertise and professionalism. From beginning to end, his psyche is uniquely present in psychoanalytic process with his patient's for better or worse, until the two reach some accord about termination.

To do psychoanalysis in this experiential field of therapy, it is necessary to redefine its actual target of inquiry into transference and countertransference. There is, for example, no point to viewing them as either patient-oriented or psychoanalyst-oriented. The particular patient and his psychoanalyst, to the extent of their respective capacities and capabilities, really *make* their therapeutic inquiry.

Just as the study of transference is no longer a patient-centered process—with the psychoanalyst hidden behind an impersonal and authoritarian facade of professional expertise, and therefore assumed to be capable of conducting an inquiry he is not part of—so the study of countertransference within the actual psychoanalytic inquiry is no longer a psychoanalyst-centered process, with the patient, this time, hidden behind a facade of submissiveness, long-suffering neurosis, character disorder, schizoid personality and more, and therefore assumed to be capable of producing insight for an inquiry he is not part of.

The point, of course, is that the very opposite is true. In psychoanalytic therapy viewed as a field of shared experience and inquiry, the study of unconscious aspects of transference centers on the psychoanalyst, since if genuinely unconscious, they are beyond the patient's scope of awareness. And all things being equal, the study of unconscious aspects of countertransference centers on the patient, since they are beyond the psychoanalyst's

scope of awareness. He cannot treat the unconscious aspects of his own countertransference until, with the help of another, he manages to penetrate his defensiveness and distortions about them. It may even be his patient who might, in this instance, be able to openly discuss them with him in a constructive way.

This is obviously not the most comfortable view for the psychoanalyst who prefers a hierarchical position of authority, or for the patient who prefers a submissive position of dependency. But uncomfortable as it may be, the unconscious aspects of the analyst's countertransference are greatly involved in the therapeutic experience; distinct and unavoidable, emergent and waiting to be observed and defined, transformed and explained, interpreted and metapsychologized.

It is these very unconscious resources of thought and feeling however, that if not evaded nor covered up, may, as countertransferred, become sources of enlightenment and healing for the patient who can see how and why the psychoanalyst, within his own psychic limits, works through the patient's resistances and anxieties in order to obtain a better grasp of his transferences. Such understanding of his coparticipant, among all the other things therapeutic taking place between them, may only arise from the patient's open observation of countertransference.

The way a particular psychoanalyst deals with his patient's reactions to countertransference, however, depends on the many private and uniquely individual factors that cannot be subsumed under any simple rule of general procedure. A psychoanalyst's reaction to his patient's reaction to countertransference depends on his given resources of affective and cognitive experience in response to that particular patient's transference, resistance and anxiety, love and hate, anger and self-pity, hostility and manipulation—or more generally, in response to the qualities and traits of the patient's relatedness in therapy.

How a psychoanalyst relates to the traits and qualities of his patient's relatedness, in turn, determines what that particular psychoanalyst can do about transforming them out of his own uniquely individual psychic resources. But he cannot possibly know how he will finally relate to any particular patient in advance of the actual therapeutic involvement. He may, at best, only work outward from the inner experience he can cultivate within that particular field of therapeutic inquiry.

If he were, on the other hand, to behave according to the pattern of some colleague's procedure—as taken over, for example,

in supervision—that would lay an impersonal, self-estranging procedure on the outside of his experience, covering it with a behavioral facade that imperceptibly moves him one step further away from his uniquely individual capacities of working directly from his own psyche with that patient.

And finally, if he cannot get through that surface behavior of procedure, into the unconscious aspects of his patient's psychology manifested in transference, resistance and anxiety, then he and his patient will enter into a dry and fallow period—an impasse, plateau, stasis—in which nothing of psychoanalytic moment can take place for either coparticipant.

In this event, the two gradually become trapped in an interlocking experience of their own making, in an inquiry so jammed that neither can pursue it fully on his own. Neither one is, in fact, able to do it without the other. And if both fail to accept their mutual dependency for living and working through it, then nothing of deeper therapeutic import can happen, and their therapeutic inquiry gradually comes to a standstill.

Whether or not they terminate the formal context of their relatedness, if neither is open to the other's hunches and intuitive moves and tentative hypotheses about their interlocking of transference and countertransference (notice that either the patient or the psychoanalyst may innovate these efforts) their therapeutic work arrives inevitably at its terminal phase. It has nowhere else to go.

At such a point, the integrity of the psychoanalyst's training and the solidity of his psychic relatedness are important determinants of what happens next. As a well-trained psychoanalyst, whose sense of personal worth and therapeutic capability does not depend on success or failure with any one particular patient, he is prepared to throw that interlocking of transference and countertransference open for shared inquiry. He may even consider turning a de facto into an actual termination, if both he and his patient have seriously attempted to explore the whys and wherefores of their particular failure at shared inquiry.

This therapeutic effort itself, pursued with intelligence and openness from both sides, may, in fact, prove to be of great benefit, because transference and countertransference, when sensitively treated, become most critical for moving the psychoanalytic inquiry forward. If insensitively treated, however, it may lead most directly to its premature failure.

This terminal phase, if not bungled through defensiveness and

distortions on either side, may prove to be the most illuminating phase of the entire therapeutic experience. Aside from what the psychoanalyst may learn about his contribution to the interlocking of transference and countertransference, the patient may learn some important things about himself in conflict, about himself relating to individuals with psychic structures like his own or his psychoanalyst's, or something important about all three.

The psychoanalyst who openly accepts the therapeutic impact of his countertransference may invoke its changing processes and patterns in order to guide and integrate the experience of both himself and his patient for the ongoing and future conditions of their work together. This, inevitably, makes the available evidence for countertransference part of his psychoanalytic inquiry with every patient, potentially involving all his thoughts and feelings, intuitions and marginal hunches, and, of course, his basic beliefs, values and ideals.

It raises, moreover, the fundamental question of how to be both a psychoanalyst behaving as professional expert, and a person experiencing a unique psyche. From a common-sense point of view, he is obviously both. But he is, I think, even more than that. For being a person is only his social and egoic or interpersonal mask, providing for gross characterizations of the subtle aspects of his inner psyche extending outward, since as its Latin derivation would suggest, the individual's persona is nothing more, nor less than the model of performance as in a play or a game. In this sense of the notion of the person, then, there is no discrepancy between being a psychoanalyst and being a person because, from the point of view of his being the uninvolved professional expert, both terms refer to his outward social and ego-interpersonal presence in the therapeutic field.

And his persona is not the same as his psyche. The differences between the two may be summarized thus: The persona refers to the objective, ego-interpersonal "me" patterns of the surface self observed and interpreted by others without, however, indicating how subjective, first-personal "I" processes express the inner self or, the deeper resources of the psyche.

This relation of the psyche to the persona, then, reveals the extent to which a psychoanalyst may become involved in therapeutic relatedness with his patient, for the nature of his involvement depends, finally, on how real and full he can become with his patient, on how deeply probing and exploratory he can

become, on how capable he is of immersing himself in the serious psychological problems of another.

Every psychoanalyst, as he moves through a series of shared experiences with a wide variety of patients, has to discover for himself the critical boundaries of his therapeutic awareness. And he has to discover them for himself because no two psychoanalysts do, in fact, possess the same uniquely individual psyche.

The attempt, however, to organize this knowledge into the structure of psychoanalytic inquiry is a different issue. For this purpose, it is necessary to formulate the rules or definitions governing the observation of transference and countertransference, resistance and counterresistance, anxiety and counteranxiety, as well as their transformation, explanation and interpretation. This structure of inquiry maps the overall limits and possibilities of the therapeutic experience available in psychoanalysis.

But again, every psychoanalyst engaging in the clinical work of therapy, not unlike the physicist or biologist engaged in experimental work in the laboratory, has to find within himself the best way to fit that structure of inquiry to the unique resources of his own individual psychology.

The structure of psychoanalytic inquiry, of course, provides a base of support for the psychoanalyst who would be himself with his patient, risking himself to his patient's transference of hostility and criticism, manipulation and destructiveness, and eventually to the full experience of his patient. For only by exposing himself with his patient to the pain and dread and misery beyond those transferences, can he practice his healing art.

But if he did not seek this experience, and instead worked over the patient from the outside of his defensive and power operations, the patient then could not, in turn, invite him to work under him from the inside of that burden of loneliness and terror, distorted though that has now become as a result of long-standing repression. And if the patient cannot become aware of it directly with his psychoanalyst, there is, no doubt, little that he may expect to do about it in any other way, in therapy or elsewhere. The acceptance of this psychic pain and misery into therapeutic awareness is an essential condition for any successful psychoanalytic therapy.

The psychoanalyst may, therefore, discover the best fit for the structure of his inquiry within himself only as he is willing, at the same time, to share the uniqueness of his psyche openly with his patient. From this shared uniqueness, he also opens the moving

center of his inner experience to those same intimations and realizations of the uniqueness of his patient's psyche. In this way, the psychoanalyst who shares his unique individuality can see his therapeutic inquiry extending outward from his affective and cognitive resources. And also see how his being a psychoanalyst, and his having a persona, arise from common roots in those selfsame inner resources of his psyche.

On the other hand, the psychoanalyst who falls back on the role of expertise presents his patient with a professional persona or trained facade. By putting up this sort of front, although he engages the patient's defensive and power operations, he is, in effect, trapped by the limits of a manipulative device of his own making.

And he also sets the stage for the patient's performance of his own suffering persona and dependent facade. But the patient's performance is simply a response to his psychoanalyst's performance and not for the purposes of furthering the inquiry. The patient is only putting up a front of defence and engaging in power operations in realistic response to his psychoanalyst doing the same with him.

The reality of this experience cannot be washed away by simply appealing to ad hoc interpretive principles, since, as Freud long ago taught and we now know well, metapsychology is like the mythical witch whose services we call upon whenever observation and inference, or logic and reason fail to support our preferred point of view. That is, if a patient responds to the professional facade a psychoanalyst covers himself with, the psychoanalyst cannot, then, turn around and claim neutrality with respect to that particular response, which, in his interpretive judgment, merely echoes the patient's experience in infancy or childhood. For the patient is responding to something real, here and now, and in that measure his response cannot be judged as being simply distorted. The psychoanalyst, whatever else he would do about it, has to treat it at least as such.

If the psychoanalyst comes on like a professional expert, and the patient tries to counter him in kind, for example by becoming testy or submissive or even combative, the psychoanalyst creates serious question about his capacity, afterward, to be the healer. For how, in truth, can an expert in procedure also heal psychic wounds? Not without relating directly to them, which he does not allow himself to do.

The psychoanalyst who plays the role or enacts the persona of

expertise, in effect, interposes an egoic or interpersonal boundary between his creative inner resources and the problems of his patient's psychology, and in so doing, also pushes the patient's creative inner resources one more step backward into himself. But if that is the way the psychoanalyst works best, and relates best, he should, of course, do it directly and straight-forwardly, although the patient, as a result, may have the added problem of getting at his own original resources with a psychoanalyst twice-removed from the resources of the psyche, once from his own and once from his patient's.

If the psychoanalyst is truly expert, however, he need only demonstrate that with the calm and depth and integrity required for the study of inner experience. And if he is not the expert he professes to be, enacting a professional facade—in therapeutic fact, a fictional facade—will not misguide or deceive his patient very long.

Aside from traces of faulty training, which every seasoned psychoanalyst overcomes in due course, another reason for enacting a social and ego-interpersonal facade is his conscious decision to cover up such countertransference problems as detachment and loneliness, hostility, sadism and destructiveness. And he probably covers them up on the judgment that they could, if opened to therapeutic inquiry, interfere with the patient's confrontation of his own problems within himself.

The psychoanalyst should not, on principle, withhold such countertransference problems from open and ongoing transaction with his patient, but in his best psychoanalytic judgment of himself, he still cannot integrate them with another on a conscious basis. He may, of course, be wrong in his judgment, and could require it as a rationalized cover for his counterresistances and counteranxieties. But that, in any event, does not automatically set any limiting conditions to his patient's awareness. It is well-known fact that regardless of his psychoanalyst's professional facade, the patient, if he is capable of such perception, gradually comes to perceive aspects of his psychoanalyst's unconscious experience whether or not the psychoanalyst would wish it, or cooperate in it.

As with transference countertransference may also be explored as it occurs in the experiential field of therapy. This effort to study its manifestations in the original field of its occurrence with the patient is the most important advance in the psychoanalysis of countertransference in the past 20 years.

The direct study of it, as a rule, intensifies the psychology of the inquiry as experienced: Instead of having, at such points, to turn awareness toward the more practical concerns of behavior, the further inquiry into countertransference within its original field of occurrence, in fact, deepens the movement of the therapy into unconscious experience as well, and does so for both coparticipants.

As the premise for this innovation of procedure, I have already indicated that the psychoanalyst's psyche and persona are as fully part of the therapeutic inquiry in countertransference, counterresistance and counteranxiety as the patient's are in transference, resistance and anxiety. And this premise, furthermore, signifies other important changes in the therapeutic relatedness of the psychoanalyst and his patient.

Consider its development in the following perspective. From Freud's (1943) and Ferenczi's (1959) mirror of id impulses, to Hartmann's (1958) and Sullivan's (1940) expert in ego-interpersonal relations, to the contemporary coparticipant in shared experience and inquiry, the psychoanalyst has gradually moved more deeply into the immediate context of his unconscious experience directly with his patient. And, in so doing, he has also learned to let go of absolute commitments in metapsychology; for its many special metaphors—such as instinctual dialectics (Freud 1943), struggle for power (Adler 1917), archetypes of the collective unconscious (Jung 1927), absolute will (Rank 1947), and so on—no longer distinguish his work as psychoanalyst. He has, in this movement, increasingly focused therapeutic inquiry on the psychology of his relatedness with his patient rather than the metapsychology of the abstract reasons for his patient's experience and behavior, and for his own as well.

This therapeutic focus is consistently set on the relations of conscious and unconscious experience as the domain of human psychology best explored in psychoanalysis, and on pursuing that exploration to the point where the patient's unique individuality engages his psychoanalyst's in direct exchange. In the overall structure of psychoanalysis, the focus is now, rather, on the pluralism of its perspectives on metapsychology, to be seen not only from the interpretive standpoint of sex and egotism, money and power, satisfaction and security, and so on, but also from the empirical standpoint of what two particular coparticipants find unconscious, and make conscious.

In this new experiential field of therapy, the psychoanalyst's

direct response to his work is affective and cognitive—liking and disliking, trusting and suspecting, hurting and pleasing, and so on—as he lives and works through the appointed sessions with his patients. He does, of course, perform a service as he applies his expertise, but he cannot possibly do that without both consciously and unconsciously living through his sessions with his various patients. He obviously is and does what he can be and do, only as capable of being there with them in therapy as he is with others elsewhere.

And this leads to the substantive question about the basic meaning of the psychoanalytic experience. Each experience, I would propose, acquires its own meanings in terms of its own ends. That is, as motive and consequence, as relatedness and significance, as live and ongoing stream of consciousness. Its basic meaning is, therefore, larger than the pragmatism of any transitional goals and purposes, and larger than the idealism of any absolute beliefs and values. But even larger than these is a psychic sense of living and becoming a uniquely individual person, a psychic sense of direction pulsating through the experience and inquiry shared by the particular psychoanalyst and patient.

Once the patient gets to the center of his first-person singular, active dimension of self—to his psychic “I” processes by which he relates to his ego-interpersonal “me” patterns—the psychoanalyst can no longer turn him aside, or off, with some arbitrary notions of procedure, such as being only a mirror, or only a professional expert in interpersonal relations when, in fact, his patient is now quite capable of perceiving uniquely individual aspects of personality, his psychoanalyst’s as well as his own.

No less than ego psychologists such as Hartmann (1958) and A. Freud (1946), and interpersonal relationists such as Thompson (1950) and Sullivan (1940) who, by the late 1930’s, took the distinction of psyche and instinct seriously, in order to study social and cultural aspects of personality, we, today, take the distinction between psyche and culture seriously, in order to study the uniquely individual aspects of each patient’s affective and cognitive resources.

But psychoanalysis, for its successful undertaking, does not require the psychoanalyst or patient to accept any one single system of beliefs and values, or myths and metaphors, nor any single interpretive metapsychology. It depends, instead, on a disciplined and intensive study of the recurrent and invariant processes and patterns of each patient’s uniquely individual psyche.

This exploration of experience is no more an alternative to, nor defense against, the modification of behavior, than the modification of behavior is an alternative to, or defense against, the exploration of experience. The two are not mutually exclusive. But psychoanalytic inquiry, as its name implies, is essentially the analysis of the psyche becoming directly available as processes of experience before producing patterns of behavior.

At this point, it may be appropriate to summarize the definition of countertransference deriving from a field theory of psychoanalysis. What sort of processes and patterns may be referred to in defining these terms? Countertransference, in its most general sense, arises from the psychoanalyst's coparticipation in therapeutic relatedness to the fullest range of experience and inquiry he is capable of undergoing with any particular patient. This finally, places his psychology as deeply into the actual psychoanalytic therapy as his patient's.

Of course, not every psychotherapy becomes a psychoanalytic therapy. In the select instances that do, the psychoanalyst may, finally, involve himself to the point of no return in a transference-countertransference neurosis, complex or interlock, in which the two coparticipants have to make the psychic effort to work through their therapeutic relatedness to another base. They do not, otherwise, obtain a better understanding of their mutual contributions to the particular shape of its development.

And furthermore, this convergence of transference and countertransference makes it necessary to place greater emphasis on the psychoanalyst's capacity to generate the inner psychic resources of affective and cognitive experience, as distinct from his ability to distribute the outer social and ego-interpersonal patterns of behavior. So his countertransference, as it involves his patient's transference, may become live, real, spontaneous instead of remaining stilted, mechanical, manipulative.

The psychoanalyst, unlike the therapist who modifies behavior, engages his patient essentially as a psychological explorer who would learn something new about the psychology of two humans experiencing each other, and whose patient is then free to decide how he will behave this new knowledge in relation to others. The psychoanalyst becomes what his name literally depicts him to be, an analyst of the psyche rather than the adaptive consensus of behavior by which he or his patient, at any given phase of the development of culture, is to experience and behave his psychic resources.

He, of course, is interested in his patient's behavior, but not primarily so. He studies it essentially as a source of observation and inference about inner experience, but not with the objective of modifying behavior. In this therapeutic inquiry, it is the patient who, finally, is responsible for both the course and consequence of his behavior, and no psychoanalyst, unless he is quite irrational, can assume any more responsibility for a patient's life than the patient does for it himself.

But while the psychoanalyst may be interested in the ongoing modifications of his patient's behavior, since he obviously cannot get closer to the private sources of a patient's behavior than the patient himself, he cannot actually modify his patient's behavior or its effects. If anyone is going to do that, and do it with some sense of freedom and dignity, it is the patient himself.

For this psychoanalytic frame of reference, we may define countertransference in the widest sense of its psychological meaning. That is, to refer to all the experience and behavior relating the psychoanalyst's psyche to a particular patient's, in so far as its processes and patterns may be observed to occur as a function of his counterresistances and counteranxieties. The important point, here, is that the psychology of countertransference may be taken to cover both his real and his distorted reactions to any particular patient.

The extent to which countertransference is real or distorted cannot be measured by antecedent perspectives on metapsychology. It is, from my point of view, a question to be decided on the basis of subsequent psychoanalytic inquiry, if at all, and finally at the terminal phases of the work. My view, here, differs from those that sharply distinguish countertransference from real feeling, real thought, real relationship, or real whatever toward the patient. And I take this view because it points up that countertransference does not arise in psychoanalytic inquiry fully packaged and defined, with a label on its wrapper indicating how much is real, distorted, etc.

There are several reasons for taking this view. First, it is better psychology because it unifies the psychoanalyst's transfer of his uniquely individual processes and patterns with the rest of his psyche. In actual clinical inquiry, the patient may, therefore, also observe his psychoanalyst countertransferring both the real and the distorted aspects of his experience and behavior.

Second, it frees the psychoanalyst to immerse himself unself-consciously in therapeutic inquiry with his patient in order to

discover whether, and in what measure, his reactions are in fact both real and distorted, the realism and distortedness of his countertransference also being a question to be answered by further inquiry.

And third, it is a constant reminder that the psychoanalyst can never shed his psychological skin and transcend the given limits of his unconscious experience, not, at least, while he lives his life under the natural conditions of human experience. So long as his experience and behavior are governed by this distinction between the conscious and the unconscious, it is naive—or perhaps more simply, even self-serving—to expect that he can ever become so completely real as to be perfectly free of distortion, but rather that he is a searching, changing, growing mixture of the two, and should always expect to be.

References

- Adler, A., 1917. *The Neurotic Constitution*, Moffat, Yard, New York.
- Ferenczi, S., 1950. *Further Contributions to the Theory and Technique of Psychoanalysis*, Hogarth Press, London.
- Freud, A., 1946. *The Ego and the Mechanisms of Defense*, International Universities Press, New York.
- Freud, S., 1943. *A General Introduction to Psychoanalysis*, Garden City, Garden City.
- Hartmann, H., 1958. *Ego Psychology and the Problem of Adaptation*, International Universities Press, New York.
- Jung, C., 1927. *Contributions to Analytical Psychology*, Harcourt, Brace, New York.
- Rank, O., 1947. *Will Therapy, and Truth and Reality*, Knopf, New York.
- Sullivan, H., 1940. *Conceptions of Modern Psychiatry*, W. A. White Psychiatric Foundation, Washington, D.C.
- Thompson, C., 1950. *Psychoanalysis*, Hermitage, New York.