

Review article

## **Countertransference in psychotherapy and psychiatry today**

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## INTRODUCTION

An undeniable characteristic of the contemporaneous psychoanalysis is the concern with the relation or the link between patient and therapist, as well as with the analytic pair during interaction. The analytic session started to be observed and studied as a relation that produces mutual emotional impact, in which there is exchange of information, i.e., communication in a verbal and non-verbal level, either intentional or not. Reflecting on transfer today means to approach what it is transmitted about the patient's, and occasionally the analyst's, mental functioning, that is, the countertransference, through what happens in the patient-analyst relation, in the conscious and, particularly, unconscious level.<sup>1</sup> The interest in understanding, using and approaching countertransference in psychoanalysis, psychotherapy and psychiatry has been the object of our interest over the last years.<sup>1-7</sup>

Countertransference allows the analyst to hear, through his feeling, not only what the patient says, but also what he **does not say**, because it is ignored in the conscious plan. Cruz Roche<sup>8</sup> reassures this evolution of the psychoanalytic object saying that "the observer (analyst) is now a participant" (p.20). Alvarez<sup>9</sup> pointed out that the patient's unconscious aspects could not only be in his or her repressed unconscious: "such absent parts or feelings could sometimes be quite more distant in the feelings of another person" (p.12).

Countertransference "was the Cinderella of the psychoanalytic technique, and its further qualities could only be seen after it became a princess"<sup>10</sup> (p.96). It is included in the psychoanalytic technique, either with its original denomination (countertransference) or with some correlated concept that comprises it, such as projective identification, analytical field, role-responsiveness, enactment, intersubjectivity and analytical third, character and possible histories, etc. It became a concept **where from** the other stem. Its meaning is not only linked to the analytical technique. The psychoanalytical theory has changed after the introduction of the concept; it became a theory of the dyad, or attachment, of phenomena that occur between the analytic pair, and not only with the patient. Thus, there is a change in the paradigm itself, because the facts are not related to a single

individual anymore, but to the interaction between two individuals, which can only be understood as a product of both. The psychology of **one** becomes the psychology of the attachment between two.

The kleinian concept of projective identification is in the core of this matter. It was the basis for the widening of the notion of countertransference, specially stemming from Bion's ideas. After Bion, several authors, from both sides of the Atlantic Ocean, have been concerned, in the field of the clinical observation, with the development and further understanding of relations established between patient and analyst during the therapy meetings.

## COUNTERTRANSFERENCE, PSYCHOTHERAPY AND PSYCHOANALYSIS

Since the seminal article by Paula Heimann<sup>11</sup> on countertransference as a patient's creation, in which she meant that the analyst's feelings during the session are somehow determined by the patient, the concept gradually imposed itself to the technical resources of psychoanalysis and derivate psychotherapies.

Racker's<sup>12,13</sup> focus on countertransference is more systematic, more global and deeper. He called the attention to conscious and unconscious manifestations and characterized countertransference as indirect or direct<sup>a</sup> and the analyst's identification as concordant and complementary<sup>b</sup>, focusing on its use as an important instrument for the understanding of the patient's object relations and formulation of interpretations.

In a variety of works, Grinberg<sup>14-17</sup> is concerned with a specific reaction from the analyst, when he or she passively receives the massive projection of the patient's internal objects. This

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<sup>a</sup> Racker<sup>12</sup> (p. 109) defines indirect countertransference as the analyst's transference regarding the "totality" of objects that, in an indirect way are transferred to the patient (for example, family, friends, groups). Direct countertransference is related to the analyst's response directly to the patient (p.113).

<sup>b</sup> Racker<sup>13</sup> (p. 126-27) understands that the countertransference is divided into: **concordant identification**, which is based on introspection and projection, on the resonance of the external in the internal, when the analyst's self finds identification with the patient's self; and **complementary identification**, when the analyst has an identification with a non intended part of the patient's self or super-ego.

author identified a specific type of countertransference expression, in which the analyst can be unconsciously lead to adopt an active role, something the patient does through the massive use of projective identifications. Grinberg named it projective counteridentification. The counteridentification seems to be qualitatively close to the description of complementary countertransference, proposed by Racker.

In 1961, the Barangers, using the presupposes by Paula Heimann and Racker about countertransference, developed the concept of “psychoanalytical field.” The dynamic field is defined as a “situation of two people closely bounded and who complete each other during the analytical situation, they are enveloped in the same dynamic process. None of them is understandable in the analytic context without the other”<sup>18</sup> (p. 129).

The authors say that “both the direct observation and the works that go further on the study of countertransference, as well as the unconscious communication means that develop in the analytical situation and the latent meanings of verbal communication, imply a much more distinct and wide concept of the analytical situation, where the analyst, in spite of his neutrality, intervenes as part of the process.” They point out that the dual therapeutic situation, with the basic organization of the field, disappears due to the “hiding of tri-partite and multipersonal situations, of multiple cleavages in continuous movement”<sup>18</sup> (p.130).

Within that context, the basic fantasy of one session is not a mere understanding of the analysand’s fantasy with the analyst, but something that is built from the dyad’s relation. And one must not only recognize the pair’s fantasy, but also understand its nature. This implies a change in the focus of approach. Firstly, an adequate theoretical focus and freedom from intellectual barriers are not enough. Secondly, it is all about a deep contact with a person with a different structure. The structure of a pair is composed of the interplay of projective and introjective identifications and the corollary of counteridentifications. The analytic situation must be managed so that it constrains the projective counteridentification and the process does not fail.

Some years later, Baranger<sup>19</sup> approached the process within the analyst's mind, from hearing to interpreting, and emphasized that the moment chosen for the interpretation (urgent point) must take into consideration what occurs within the "intersubjective field", which comprises both participants. He draws the attention to the fact that, sometimes, during the process, the intersubjectivity of the analytical dialogue can become "invisible or inaudible", composing something like a second structure.

The concept of "field" widens the Freud's patient-analyst relation concept, later used by Melanie Klein, because it can be extended to the entire analytical situation, and consequently to the setting and to the technique, allowing a broader view of the process.

The ideas of Baranger and Baranger<sup>18</sup> about the characterization of the analytical situation as a "bi-personal field" are very up to date, with many significant points in common with that of many other current analysts.

North-American authors, such as Ogden,<sup>20-23</sup> and European, as Ferro,<sup>24-30</sup> describe similar phenomena, with different nomenclatures, when they approach the analytical field phenomena. The idea they seem to have in common is that of a subjective space built by the dyad patient/analyst, where unconscious phenomena take place and where conscious phenomena are brought, giving each analytical process particular characteristics.

The intersubjectivity that emerges from the pair, who can transform it by using their own observation ability, is then outlined through the constitution of the analytical third. The individual features, however, are not suppressed, as each component of this pair has particular personality traits and different roles, that will be unconsciously experienced and practiced, by recreating the present and the past in each mind, with the focus being the patient's experiences.<sup>21,23</sup>

Ferro<sup>24,28</sup> emphasizes the interrelational aspect as something that should always be interpreted, but which is invariably a fertile mean where from changes and transformations will emerge. Such understanding finds support both on Bion's<sup>31,32</sup> and Ferro's<sup>25-27</sup> (based on Bion) understanding of transformation as a therapeutic aim of the field, which builds the space where

from transformations of the analysand's and analyst's transgenerational fantasies may occur, in a continuous movement of mutual learning. Following this line, Ferro<sup>26,29,30</sup> proposes that hearing should be based on the notion of **character** and of the roles each one undertakes during the session, as a mean of narrating all **possible histories** that may develop in the patient's unconscious and in the analytic field, and as a factor of cure in the suffering genesis.

The countertransferential position, as pointed by Faimberg, does not depend only on the patient's transference, even though it has a central role. The author says that "the vicious circle resulting from the pair's psychic absence"<sup>33</sup> (p.88) can be better understood from the analyst's countertransferential position, when the analyst develops the function of "hearing of hearing" of his or her own interpretation, which the patient has already interpreted.

Although there are differences among the different theoretical schools of psychoanalytic thought, a strict convergence area has arisen as to the utility of countertransference as a technical element to understand the patient.<sup>34</sup> There is a common agreement that the patient will inevitably try to make the analyst an object of transference. The analyst's countertransference will also allow for a joint creation, with the patient's and analyst's contributions, which can reflect the patient's internal world. Different schools, however, discuss the ways how it can be employed in the clinical practice.

A significant number of works<sup>35-38</sup> has been published that review the concept of countertransference in the Latin America, North America and Europe. Although such works approached the issue from different critical points of view, they agree with Gabbard<sup>34</sup> in that there is a common area of convergence: its clinical importance. As recent research has evidenced,<sup>5,7</sup> there has been a tendency towards the use of countertransference in the psychoanalytic supervision.<sup>5,7</sup>

In a synthesis of the current (from the 1990s on) scenario on the study of countertransference, Manfredi<sup>39</sup> describes five **tendencies** in the approach of the issue:

- countertransference is no longer considered solely the patient's creation, the analyst's transference is now taken into consideration;

- it is difficult to differentiate the normal countertransference from the pathologic one (usually, the information the analyst accesses do not allow to make such a discrimination).
- Some authors<sup>40</sup> consider that tolerating the countertransference would be enough, once the differentiation between the pair's feelings is difficult to be performed.
- we should be humbler and wiser, and make the opposite route as well: to look for ourselves in the patient and not only to look for him within us.
- the matter of confessing or not, or how much or when to confess/reveal countertransference feeling (there are arguments in favor and against). Manfredi emphasizes that the issue of how to manage it is still open and occupies a central role in current clinical-theoretical debates in psychoanalysis.

## COUNTERTRANSFERENCE AND PSYCHIATRY

On the other hand, a closer relationship between psychoanalysis and neuroscience has been seen lately.<sup>41</sup> Studies on the brain basis of unconscious phenomena carried out by neuroscientists have revealed the neural fundamentals of psychic processes described since the beginning of psychoanalysis. Among them, the relation between mother and baby through preverbal unconscious communication, which has showed that mood regulation between them is essential for **maturation of the baby's brain structures**.<sup>42</sup> Such affective regulation/communication is stored as a procedural memory (unconscious), which follows and keeps different neural paths than those used in the explicit memory (conscious and verbal), not developed by the baby. The procedural memory is **content-free**, it is involved in acquiring sequences of actions.<sup>43</sup>

By observing and studying the mother/baby interaction, Stern (2000)<sup>44</sup> says that in dynamic psychotherapies, two types of knowledge, representations and memories are built: the explicit (conscious, symbolic) and the procedural (unconscious, non-symbolic, non-verbal), which is named **implicit relational knowledge**. Such knowledge, essential in the psychology of babies'

development before language acquisition, is the basis of the interaction and communication of mothers and babies. “A vast list of implicit knowledge about the myriad of ways of being with the others,” says Stern, “continues in the course of life, **including the many ways of being with the therapist, which we call transference**” (p.199).

Such conclusions, briefly outlined here, confirm what the psychoanalytic theory (after Melanie Klein and Bion) has been claiming since the 1940s and 1950s about pre-verbal, unconscious and primitive communication between the child and his or her mother. They confirm what the post-Freudian psychoanalytic technique says about the best way of understanding transference: “Much of our understanding of transference arises through our understanding about how our patients **act upon us** to make us feel different things for the most different reasons (...), how they **act** unconsciously with us in transference, trying to make us act as them. (...) If we work only with the verbalized part we do not really take into account the object relations that are enacted in transference, for example, the relation between a not so understanding mother and the baby that feels unable to be understood, and this is the basis of its personality” (p.164).<sup>45</sup> This author, a kleinian analyst, is saying that the adult, in the neuroscientific thought, retains the primary object relation in the procedural memory, and its manifestation is only apprehended by the analyst through **the action on transference**, and not through the speech. The analyst, on its hand, can only catch such transference through countertransference, through what he is taken to feel as the **patient’s action** upon him. There are no words in this communication, because they are preverbal primitive experiences. Only when bringing the feeling to consciousness, this means, when it is captured by thought, therefore passing to the explicit, verbal memory, the analyst will be able to interpret what happens between them and tell it to the patient.

Today, we count not only on the psychoanalytic study of the unconscious communication from patient to analyst (the transference/countertransference phenomenon) that follows the basic model of real repetition of the baby’s primitive relations, but also on the new model, which



aggregates the neuroscience studies to the previous one (type of memory – and knowledge – that arise from the initial, non-verbal and life-lasting interaction).

In a wide spectrum, psychiatry itself can no longer dispense the concept: the psychiatric patient is more understandable in its reactions and interactions with the physician and with the care providers when he can see their reactions. The use of medication, acceptance and compliance to treatment can be more fully understood if the psychiatrist makes use of its feelings and tries to understand the link between him and the patient, *either he or she is psychotic, borderline or neurotic*. Thus, countertransference is not only related to the analyst's feelings during sessions, but it means the wide use of the analyst's/therapist's/clinician's subjectivity to a fully understanding of the patient. It comprises not only shallow phenomena, that can be seen, but especially hidden, obscure unconscious feelings and meanings of each individual, that determine and define his behavior.

The contemporaneous psychiatrist, this way, can not ignore the importance of using and consulting his/her own feelings towards the patient. Some aspects of the patient can only be understood when the feelings mobilized in the psychiatrist are considered. The discomfort the therapist feels when treats a depressed patient that does not speak much is a mute (verbal) way of expressing the patient's fear of succumbing to suffering and attempting suicide. The patient conveys this fear to the therapist unconsciously and not verbally. This fear is captured and felt as a discomfort unconsciously by the psychiatrist as well, who will understand it not only as his feeling, but as something built from their interaction to express an unconscious emotion of the patient.

## CLINICAL MATERIAL AND DISCUSSION

An interesting example withdrawn from an experience of supervision<sup>6</sup> will be described in order to illustrate the usefulness of transference in the development of analytically-oriented psychotherapy. A young and dedicated psychotherapist, who lived in a town in southern Brazil (Rio Grande do Sul) and commuted weekly to the capital Porto Alegre to attend his specialization course

in Analytically-Oriented Psychotherapy and assist some of his patients presented the following clinical material in a supervision.

The patient had been attending psychotherapy sessions for 1 year and a half, twice a week during 45 minutes. She looked for treatment because she felt sad about stagnation in her life. She graduated from university but she felt very hard to start her professional career and undertake responsibilities. Most part of the time she “rehearsed” how she could work or perform any activity. A similar difficulty was found in love relationships, which she started to avoid after some not well-succeed relations, due to excessive controlling and aggressive behavior. There was a strong attachment with the mother and defensive hostility towards the father, with whom she avoided contact.

The psychotherapist had been showing the strong attachment she had with parents, specially the mother and the fear of growing up and separating from them. He interpreted the patient’s transference desires of obtaining quick and rapid answers as a way of obtaining infantile gratification and, thus, producing little changes in the treatment, avoiding the separation from the therapist, which would occur one day.

After 1 year and a half, the patient had reached a considerable improvement, she had a job that she took very seriously and with dedication. In parallel with her job, she had a date with a boyfriend with whom she started an intense relationship, which invariably made her controlling and aggressive characteristics to flourish, frequently examined during sessions.

The psychotherapist, on his turn, had already presented tiredness during supervision with weekly commuting (trips to the capital) to continue with his studies, which were almost coming to an end. He showed his gratitude with supervision and with his course, which had had an influence on his growing and learning. He was regretful, however, because he was losing his life quality due to constant commuting, to hours dedicated to studies and worries with his professional future. At the same time, he started to worry with the end of its study period, with the definitive return to its town and with the interruption or end of the psychotherapy sessions with his patient in the capital,

once he felt they would not reach the proposed objectives completely. This topic was approached during supervision, and we had come to an agreement that he should continue with the psychotherapy sessions and should pay attention to the constant activations the patient made in order to accelerate to process and obtain quick answers and results, as it had already happened in the past. We have set the end of the year, about 2 or 3 months before, as the best moment to communicate the end of the therapy and the reasons why it was being finished to the patient, so that they would have time to talk about the issue.

The patient, on her turn, showed great anxiety with relation to the considerable changes she made in her life, as working and dating, and she started to have strong worries with her still reduced ability of self-maintenance. Besides that, her mother, with whom she had a joint current account, sometimes spent too much and committed part of her earnings.

During one of the sessions, the patient was anguished with financial matters and proposed the reduction in the frequency of sessions, which the therapist did not hesitate accepting. During supervision, the therapist immediately recognized that something had happened during that session that was making him feel a discomfort (frustration) and, soon, he associated that with the fact of accepting the sessions reduction without having examined the issue carefully, as he usually did.

By discussing the case and the procedure, we thought the patient made him take precipitated decisions (an enactment, as described by Jacobs<sup>46</sup>), as she had already tried to make in the past. This time, however, she was **backed by the therapist**, who was supported by his tiredness with commuting, with the end of the course and with his decreased quality of life, which was currently in contrast with that of his patient. We realized he felt pressed to act and give something to the patient immediately. As a hypothesis to be investigated we considered that the patient's anguish with her "reduced income" could represent her communication of unconscious perception about her uncertainty as to personal conditions of proceeding alone in the path indicated during sessions, after future interruption. On the other hand, it seems that through the use of the patient's projective identification, there was the psychotherapist's projective counteridentification (in Grinberg's terms)

with the anguishes of separation from the patient. According to Racker, we could say that there was a complementary identification with parts of the patient's self in the countertransference (anguish with the separation from the object). The initiative of reducing sessions by the patient seems to have brought a relief to the psychotherapist, who did not have to communicate her about the decision of returning to his city after the conclusion of the course and the consequent end of treatment.

## FINAL CONSIDERATIONS

It is not a casualty that when some authors<sup>10,33,39</sup> discuss this topic they refer to it as the **problem of countertransference**; this means that in spite of the immensurable advances in the psychoanalytic technique and theory, there still have questions in countertransference which were not answered, making it a stimulating though difficult field of study. When outlining the current tendencies of the debate and study of countertransference, Manfredi does not refer to authors as Thomas Ogden or Antonino Ferro, who contribute consistently and creatively to the study of the technique. He refers specially to technical issues, not to theoretical ones, as the current contributions of the empirical studies on the mother/baby relation and neuroscience. He also does not approach issues related to other denominations of countertransference in other schools (as, for example, the enactment and the intersubjectivity perspective approach, both from the American psychology of the ego) and the implications of such differences. As we see, there is still much to research, discuss and learn about countertransference.

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#### **ABSTRACT**

*The goal of this article is to demonstrate that even though there are differences between different theoretical schools in the field of psychoanalysis, a narrow convergence area has emerged: the utility of countertransference as a technical element to understand the patient. Countertransference is included in the techniques of psychoanalysis, either with its original denomination (countertransference per se), or with some correlate concept that comprises it, such as projective identification, analytic field, role-responsiveness, enactment, intersubjectivity and analytic third, character and possible histories, etc. It is a concept upon which other concepts are built but its meaning does not concern only to technique. The psychoanalytical theory has changed after such a concept, becoming a double theory, or an attachment theory, about phenomena that occur between patient and therapist, and not only with the patient. In this sense, there is a paradigm change, as the facts are not related to a single individual anymore but to an interaction between two individuals, which is understood only while a product built from both. The psychology of one became the psychology of the attachment between two. The article emphasizes how a technical element can be useful in psychiatry, psychotherapy and psychoanalysis. The use of medication, its acceptance or not, and compliance with treatment or not can be better understood if the psychiatrist uses his or her feelings and makes an effort to understand the attachment between patient and therapist, either he or she is psychotic, borderline or neurotic.*



*The authors conclude that countertransference is not only about the therapist's feelings during meetings, it means the wide use of the analyst's/therapist's/clinician's subjectivity to fully understand patients, as not only visible shallow phenomena will be approached, but also hidden, obscure feelings and meanings that underlie the unconscious of each individual, which determinates and defines the patients' behavior.*

Keywords: *Countertransference, projective identification, psychoanalytic technique, psychotherapy.*

Title: *Countertransference in psychotherapy and psychiatry today*

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