COUNTERTRANSFERENCE IN PSYCHOTHERAPY: IS IT AN IMPEDIMENT OR BENEFICIAL?

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Abstract: *There is a common understanding that countertransference is an impediment in psychotherapy. This article explores the beneficial aspects of countertransference and the significance on attending to countertransference in psychotherapy supervision. A distinction is made between Reactive Countertransference which is not therapeutic and a Responsive Countertransference which is therapeutic. Two psychotherapy examples are provided that describe the author's therapeutic use of countertransference.*

Keywords: *countertransference, responsive countertransference, reactive countertransference, integrative psychotherapy, client-therapist relationship, supervision*

In a previous article I reflected on the various phases of supervision in psychotherapy [1]. I described a framework of supervision that I have found useful in organizing my approach to professional training, case consultation, and psychotherapy supervision according to supervisees' levels of therapeutic acumen. I wrote about the responsibilities of the supervisor in promoting competent, ethical psychotherapists and focused on how skill-development is important in the early phases of supervision because it provides the supervisee with a solid foundation for applying theory into clinical practice. My colleagues Loredana Vîșcu, Clifton Edward Watkins Jr. and I used the concept of a "pyramid" as a metaphor that describes the various levels of supervisees' development in becoming a competent psychotherapist [2].

During the early phases of supervision, I want to help the supervisee strengthen their skills in making interpersonal contact, develop their capacity for affect, developmental and rhythmic attunement, and consistently use phenomenological, historical and relational inquiry [3]. It is often necessary to re-teach concepts and interventions which the supervisee has learned previously with the focus on how the concept or method may be applied in a specific therapy situation.

Since the primary focus at these skill-development phases of supervision is on increasing the trainee's level of information on how to do psychotherapy, I generally do not focus on any possible countertransference unless such countertransference is interfering with the supervisee's capacity to be fully present and therapeutic. However, while listening

to the supervisee present a case, I frequently ask myself the question, "In addition to telling us about the client, what is the supervisee revealing about their Self? This question provides us with a bridge to discuss the concept of countertransference in psychotherapy as it emerges in supervision.

COUNTERTRANSFERENCE

In my early years as a psychotherapist the concept of "countertransference" was the bane of my existence. I suffered whenever a supervisor or colleague implied that I was in countertransference with my clients. I believed that countertransference was irrefutable evidence that something was wrong with me as a psychotherapist. I was ashamed when I worried that my clients were in crisis, or when I felt tenderness and protectiveness, or when I was irritated or bored. In my superficial understanding of countertransference, I believed that if I had an emotional reaction in response to my clients, it meant that I was unconsciously reliving some unfinished aspect of my own life and enacting it within the psychotherapy. After all, I knew that Sigmund Freud and other psychoanalytic writers postulated that countertransference was the analyst's transference of old emotional reactions onto the client, hence a hindrance in the psychotherapy. Freud [4] wrote that countertransference was the "result of a patient's influence on his [the psychotherapist's] unconscious feelings" (p. 144).

Later in my training I read Donald Winnicott's article entitled "Hate in the Counter-Transference" [5], in which he depicted countertransference as having two dimensions: first, as personal countertransference which he, like Freud, defined as the psychotherapist's emotional and behavioral reactions to the client that are based on their own unresolved issues. The second dimension Winnicott termed objective counter-transference: the tender, understanding response by the psychotherapist that may be needed by a client who was consistently criticized as a child. Winnicott saw objective countertransference as normal, understandable responses "to the actual personality and behavior of the patient" (p. 60). Paula Heimann [6] elaborated on Winnicott's idea. She said that the psychoanalyst's total emotional reactions to the client were often an indicator of what was happening within the client's unconscious. This idea, along with many discussions with colleagues about our internal responses to clients shifted my understanding of countertransference. I no longer viewed countertransference as solely my personal failure; *countertransference may also be the gateway to understand the client's unconscious experience.*

Heinrich Racker [7] furthered Heimann's ideas and delineated two distinct types of countertransference: concordant and complementary. In a concordant identification, the psychotherapist is stimulated by the client and responds to them with empathy. In a complementary countertransference, the psychotherapist identifies with the client's internal "other" and responds with indifference, boredom, disdain, superiority, or merely a lack of empathy. Otto Kernberg [8] reiterated Racker's ideas when he described countertransference as being present in any therapy situation because of two factors: the therapist's history of relationships and the feelings induced by the client.

Heinz Kohut [9] defined the concept of self-object transference as an unconscious portrayal of significant others onto the psychotherapist and how such a portrayal mobilized countertransference in the psychotherapist. Kohut proposed that in order to understand the

client's intrapsychic process, it is essential that the psychotherapist be introspective about their own feelings and fantasies—and to then use their phenomenological experience to empathically respond to the client's subjective experience. Greenberg and Mitchell [10] defined countertransference as "an inevitable product of the interaction between the patient and the analyst rather than a simple interference stemming from the analyst's own infantile drive-related conflicts" (p. 389). This is what Stolorow, Brandschaft, and Atwood [11] described as "intersubjective" — the melding together of two unique perspectives.

Sandor Ferenczi [12] was the first psychoanalyst to propose that countertransference was the psychotherapist's identification with the client's unconscious communication, and therefore, countertransference constituted an essential component in understanding the client's relational history and inner life. Ferenczi declared that the psychotherapist's feelings of tenderness, patience, and concern were the core of the relationship between therapist and client. However, classical psychoanalysis continued to characterize countertransference as the analyst's transference of their own internal conflicts into their relationship with the client [13].

Ronald Fairbairn [14] elaborated on Ferenczi's ideas when he called for "genuine emotional contact" (p. 16) in the practice of psychotherapy—a form of intimacy from the psychotherapist to the client that provides the client with a new, transformative relationship. Harry Guntrip underscored Fairbairn's relational perspective when he wrote, "It is the psychotherapist's responsibility to discover what kind of parental relationship the patient needs in order to get better. . .. If the psychiatrist cannot love his clients in that way, he had better give up psychotherapy" [15].

MY COUNTERTRANSFERENCE: IMPEDIMENT OR BENEFICIAL?

When Loraine came for her first psychotherapy session, I was repulsed by her. Over the phone she was pleasant but when she arrived, I discovered that she was slovenly dressed with unwashed hair that smelled like mold. Her teeth were obviously in need of dental repair. I wished that she had not come to my office. Yet, in our initial session I sensed that she was serious about improving her life which stimulated me to commit myself to being fully present with her.

During the next several weeks I became fascinated by her intellectual brilliance, her articulate language, and her frequent quotations of literature but, at the same time, I could not escape my sense of repulsion. Listening to her was interesting but I did not want her to sit close to me. I wished that I could hold my breath for an hour. I certainly did not want her to ask me for a good-bye hug. Disgust may be too strong a word to describe my feelings but I certainly had a strong urge to turn away from her. Staying in contact with Loraine was a constant struggle. I was committed to doing an effective psychotherapy with her but I was conflicted: I had both a sense of repulsion and intense tender concern.

We were many months into the psychotherapy before Loraine allowed me to inquire about her childhood relationship with her mother. When she talked about her childhood she reported stories of perpetual neglect, such as wearing the same clothes for a few weeks at a time and eating the same rice soup every day because her mother "didn't like to cook". "Our apartment was always a complete mess, everything was dirty". She reported that notes were sent home from both kindergarten and elementary school asking

that she be bathed and her hair washed before returning to school. I wondered if my sense of repulsion was only my own proclivity, a reactive countertransference, or was I sensing and identifying with her mother's emotional reactions to her.

In subsequent sessions she talked about the absence of any conversation with her mother. "She always watched TV". "There was never any closeness." Loraine said that her mother never wanted to touch her, and certainly not give her a bath. The few times she recalled having a bath she remembered her mother screaming that Loraine was making a mess. In reaction she stopped taking baths. When she was an adolescent her mother admitted, "I wish you had never been born". I was emotionally impacted by Loraine's recounting her relationship with her mother — a relationship that was consistently neglectful of Loraine's physical and relational-needs. I had two intense responses. I felt a protective tenderness for the neglected child and I felt anger at her mother's disregard for Loraine's welfare.

As Loraine continued to tell me stories of how she was uncared for I thoughtfully examined my sense of "repulsion". While at first, I assumed that my feeling of repulsion was my own, I began to wonder if I was picking up on some unconscious communication encoded within her stories. One day I inquired, "I wonder if your mother was disgusted by you". She immediately responded with, "That's it. That's the word …DISGUSTED, that describes my mother…she was always repulsed by me."

My sense of repulsion and my subsequent inquiry revealed an integral part of Loraine's childhood experience. My repulsive reaction had provided me with a window into the distain Loraine's mother felt about her; my sensations allowed me to come up with the word "disgust". For almost a year I was non-consciously identifying with Loraine's mother's attitude of "disgust" and assumed that it was mine. Yes, her musty smell remained but what was now most important was my anger at her mother's neglect of Loraine and my desire to be protective and gracious to the child she once was. Our therapy eventually addressed how Loraine replicated her mother's behavior by neglecting her own appearance, cleanliness, and health.

TRANSFERENCE AND COUNTERTRANSFERENCE

I have come to think of countertransference as the psychotherapist bringing into the therapeutic encounter their own internal organization of life's experiences, their unique way of creating meaning. Our childhood and school experiences, the quality of our early and current family relationships, the joys and sorrows of our love life, the things we dislike or avoid, what we read and the music we enjoy, our professional training, theories on which we rely, the style of how we transact with our clients --- all of these individual proclivities form the unique substance of what we psychotherapists bring to each therapeutic encounter. When we consider this perspective, every moment of psychotherapy involves the interplay between two people, a co-constructive process.

In discussing countertransference, it may be useful to have a common definition of transference. In Integrative Psychotherapy [16, 3] transference can be viewed as *"the expression of the universal psychological striving to organize experience and create meaning. It can also serve as the means whereby the patient can demonstrate his or her past, the developmental needs which have been thwarted, and the self-stabilizing procedures which were erected to compensate*." [17].

If we emphasize the second part of this definition we focus on the relational disruptions in the person's life, their unrequited relational-needs, and how they have managed to stabilize and regulate themselves. These stories are revealed, often without awareness, through physical gestures, unaware enactments, snippets of memory, or metaphors [18]. Consequently, the transferences that occur in the process of psychotherapy may be the client's unaware attempt to reveal and heal. If we emphasize the first part of this definition, the "*universal psychological striving to organize experience",* then we are all in a form of transference all the time. We cannot escape our own way of organizing a lifetime of experiences. Transference is simply the idiosyncratic way we express ourselves. We transfer our unique predisposition into every situation.

Is "countertransference" transference? Yes, according to the definitions of transference that I am suggesting, we live within our own internal organization of life experiences: physically, affectively, cognitively, and behaviourally. In a simple definition we can say that *countertransference is composed of the emotional, imaginative, and/or behavioural reactions of the psychotherapists that are stimulated by the client's interpsychic and behavioural processes.* These internal responses of the psychotherapist may be in attunement with what the client needs in order to heal from their emotional and relational wounds or they may reflect an emotional resonance with what the client is *unconsciously conveying*, such as the introjection of the thoughts, feelings, or personality traits of significant others. Heimann [6] defined countertransference as "all the feelings which the analyst experiences towards his patient" (p. 81), whereas Winnicott distinguished between a personal reaction to the client and an objective response—what Racker called complementary and concordant countertransference. In Integrative Psychotherapy we use the terms "reactive" and "responsive" to describe the psychotherapist's various forms of nonverbalized interaction with their client.

The term *reactive countertransference* describes the psychotherapist's affects and behaviours that are an expression of their own internal conflicts, often in reaction to their client. We are in a reactive countertransference *w*hen our transactions with our clients are unconsciously tinged with unresolved anger at someone in our own life; if we are inhibited by our own grief and fears; when we disavow our own emotional history; when we are constrained by remnants of loss or trauma; or, when we are confined to a specific theory. When there is a reactive countertransference the client-therapist dialogue becomes a manifestation of the psychotherapist's own internal conflicts and unsatisfied relational-needs; the psychotherapist's communication is no longer in the service of the client. This is what has been traditionally thought of as countertransference.

We provide a *Responsive Countertransference* when we are in attunement with our client's affect, rhythm, and developmental level of making meaning; when we are compassionate with their sadness; when we are angry at the person who abused them; when we are patient and sensitive to their needs; and, when we communicate with sensitivity, respect, and choice. In each of these circumstances we may be engaging in a responsive countertransference — attunement to what the client requires in a healing relationship [19].

Reactive countertransference is counter-therapeutic, whereas responsive counter-transference can promote the client's healing and growth. Each psychotherapist has their own natural inclinations and demeanour — some tend to be quiet while others are more exuberant, some are sensitive to the client's affect while other's attend to how the client is reasoning. It is essential that we psychotherapists remain aware of our own relational-needs

and cognizant of how our needs influence our therapeutic dialogue [20]. This is the ethical reason why it is essential that psychotherapists engage in their own in-depth psychotherapy, extensive supervision, and frequent communication with professional colleagues. Each psychotherapist, even if using the same theories and concepts as others, will conduct their interactions with their clients in a different manner. The central challenge for each psychotherapist is in how to make use of our natural proclivities in providing for our client's welfare. This requires acceptance and appreciation of our own natural inclinations. It requires that we be vigilant as to how our affect and behaviour may influence our clients.

MY COUNTERTRANSFERENCE WITH HENRY

Henry also impacted me, but in different way than Loraine had. Henry was a successful actor who in our first session described himself with "something is missing within me." Over the next few months, I listened to Henry's constant sadness and stories about his loneliness when he was a boy. I resonated with his lament. He touched my heart. I had the sense that his sad expressions were those of a 5 and 6-year-old boy who longed for the playful companionship of his father. Perhaps I was particularly sensitive to Henry's developmental needs because I too had lived without a father's caring involvement. I wondered if I was experiencing a reactive countertransference when I envisioned Henry being a young boy, alone with no emotional support and guidance, longing for someone. In one of our early sessions he cried, "I need my father to be with me, to play with me, to help me make things." Over the next few months, I had a "developmental image" of young Henry [21] and used that image to form several inquiries about his life and the quality of his relationship with his parents when he was in his early school years. I asked Henry many questions about his early life: about the play he enjoyed and who played with him; what occurred in the family before he went to school each day; who greeted him when he returned from school; the type of communication at the family table; and, his bedtime routine. His memories of these important every day incidences were filled with sadness and longing, an empty sense that "something is missing in me".

Henry cried as he told me about never being sure if his father would visit him or not on weekends. "Sometimes he would take me to meet his friends in a bar, but I hated that smelly bar. I just wanted him to teach me how to play ball." Henry longed for his father's involvement. He sobbed as he said, "I loved playing with Lego but he was never interested". In response to my consistent inquiry, he also talked about his "absent-minded mother". "She was always too busy or too tired to play with me or even help me with school work." He cried, "I was in a lot of school plays but neither of them ever seemed interested."

As I think back on the psychotherapy I did with Henry, it is clear that I acknowledged his relational-needs that he had when he was a child and I also responded to his need as an adult to have someone who was interested in his activities and who shared in his experiences. Throughout our psychotherapy, I expressed interest not only in his history but in many of the activities of his life. I inquired about the TV scripts he was reading and how he made the characters he played come alive. I focused on his relational need for a shared experience and the companionship that had been missing during his young life. With my consistent involvement, Henry's persistent sadness dissipated, he terminated his psychotherapy with a sense of enjoying what he was accomplishing in his career. But I'm left with a question. Was my countertransference reactive or responsive; or both?

CONCLUSION

Over the years, in my own psychotherapy and supervision, I have investigated the various aspects of my countertransference. I have also explored the countertransferential experiences of many supervisees. It is apparent that countertransference begins with our identifying with our client. This is why it is essential that psychotherapy trainees, and even experienced psychotherapists, engage in their own in-depth psychotherapy, ongoing supervision, and case discussions with other psychotherapists.

In providing a comprehensive psychotherapy, it is essential that the psychotherapist attune to the unintegrated and unaware aspects of the client, such as their physical sensations, affects, stabilizing fantasies, or unrequited needs. We may also identify with some features of an internalized significant other, such as a father's criticism, a mother's lack of tenderness, or a grandmother's harsh expectations. At first, we may mistakenly identify these aspects of the client as emerging from ourselves when, in actuality, they represent unrecognized interjections. The story of Loraine's psychotherapy provides an example of how I was influenced by her unconscious communication of her mother's "disgust". I used this unaware identification — what I experienced as my "repulsions" — to eventually shape my inquiry about her mother's attitude toward Loraine. Identifying her mother's attitude and behaviour toward Loraine changed how I felt when in Loraine's presence, as well as the direction and depth of our psychotherapy.

As I said earlier, Henry also influenced me, but in different way than Loraine. Henry's sad stories stimulated me to remember my own loneliness and yearning for a father's attention. In the midst of our psychotherapy sessions, I experienced memories of my loneliness and longing as a young boy --- potentially a reactive countertransference. Yet, I used those memories of what I needed from my parents, particularly a father, to guide my inquiry into Henry's experience with his parents. Recalling my own experience as a child made it possible for me to be sensitively attuned to Henery emotional experience; what began as a reaction became a responsive countertransference. When we are fully involved with our client, when we are committed to our client's welfare, we cannot avoid being in countertransference because our countertransference is composed of our emotional, imaginative, and behavioural reactions that are stimulated by the client's intrapsychic and behavioural processes. Let us embrace the concept of countertransference and use it responsively, in the service of our clients.

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