ROUTLEDGE 2008 WHAT IS THIS THING CALLED LOVE?

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Countertransference

"Look, there is no right and wrong here, but I'm going to side with Helen because I'm a girl."

Countertransference is composed of the therapist's personal or subjective reactions to the patient, and is usually thought to include all of his or her responses, conscious and unconscious – with particular attention being paid to those responses that constitute a departure from the therapist's typical therapeutic style. As is now well known, these reactions were originally regarded as an impediment to psychoanalytic treatment. Freud did not doubt that countertransference was an "insidious obstruction to the analyst's benevolent neutrality, a resistance to be diagnosed and defeated" (Gay, 1988, p. 254).

Gay cites Freud's 1910 paper on the future prospects of psychoanalysis: "The analyst must recognize this countertransference in himself and master it . . . every psychoanalyst only gets as far as his own complexes and inner resistances allow" (p. 254). Perhaps the admonishment was meant for Freud himself and his dearest colleagues, for what Freud learned very early on from his own work with Dora and from Breuer's experience with Anna O. was that therapists could be hurt, they could be made angry, and they could be tempted to respond to seductive behaviour, and that these emotions seriously clouded a therapist's perceptions. Still, the awareness of countertransference seemed to come as such a surprise that it is no wonder Freud tried to shake it off at first, advising his colleagues and students to have more analysis to get rid of it.

Just after Freud's time, it was thought that we should give countertransference more attention and more study, if only because it was seen to be stirred up by the patient. Theorists agreed that some of the feelings evoked in the therapist had been projected into or onto him or her by the patient – in the case of couples, we would say by both patients – for defensive, evacuative purposes and also as a means of communicating a person's internal world. The task of the therapist was then to become consciously aware of what feelings and fantasies were being aroused, to make some sense of them, and to offer some understanding to the patient(s) through an interpretation or comment (Ruszczynski, 1993), or possibly even an enactment – hopefully to be analysed.

Later, the relationalist ideas about the therapist's subjectivity added another dimension to our understanding of countertransference phenomena. The concept of countertransference was broadened to include the therapist's contribution, in response to the patient's transference, to the patient as an individual, and to the material brought into the sessions that related to specific unresolved issues in the therapist. The many ways in which the patient gratified or frustrated the therapist were also seen as evoking countertransference reactions. Now hailed as "the news from within," it is seen as a most important source of information for the

therapist, and in some limited cases, for the patient, on many levels of the therapy.

Siegel (Solomon and Siegel, 1997) talks about the selective factor in choosing psychotherapy as a career, suggesting that as therapists we bring a certain commonality to the countertransference: "a need to relate more intimately to others, to understand oneself better, to repeat a pattern of caretaking that began in childhood, to resolve personal problems, or to meet needs for power, admiration and love" (p. 6).

Although there has not been a great deal of research in the area of countertransference in couples work, what has been written so far is extremely thoughtful (see, for example, Solomon and Siegel, 1997). Being in a triangular situation is usually our first experience of family life, yet it is often one of the most difficult to manage successfully. Triads too often become coalitions of two against one, or fusions of two or three members into pseudomutuality, or even collusive distancing (Guttman, 1982).

In working with couples, opportunities to meet one's caretaking needs are omnipresent. Voyeuristic urges, even though consciously denied, can be gratified almost too easily as the therapist peers into the intimate workings of the couple's relationship. In addition, Frank (1997) states, and I agree, that too often couples therapists fail to explore oedipal issues, focusing instead on narcissistic injury and rage, fears of abandonment, and on exposing pathological projective identification. Frank feels that this avoidance is due to oedipal countertransference anxiety – in other words, a fear of dealing with one's own oedipal conflicts. He gives as an example a young therapist who may shy away from openly discussing the couple's sexual life because of his childhood prohibitions against sexual curiosity about parental intercourse. There is also the risk of repetition of a childhood need to repair a parental marriage that is perceived as bad, whether depressed or violent. We sometimes can notice this when we begin to offer suggestions to the couple, rules to live by. Same-sex rivalry, where the therapist unconsciously competes with same-sex partner to show the other-sex partner that they are

the better, more understanding spouse, is also an indication of oedipal countertransference.

The current relationship life of the therapist – whether he or she is in an intimate relationship, wants to be or doesn't want to be; whether their relationship is relatively smooth or highly stressful; or whether they are recently divorced – will affect their work with couples.

Since the couple's impossible, idealizing expectations, referred to in the last chapter, may include the therapist fixing a marriage *and* fixing two individuals, the opportunities for arousing grandiose and saviour fantasies in the countertransference are many.

Every facet of the couple's therapist's work creates the risk for overidentification, envy, feelings of exclusion and grandiosity, and even regression, in facing two people who are intensely involved in a troubled relationship, and wanting a their help. Countertransferences in couples therapy are often more frequent and compelling than those of the individual therapist, and are usually more complex, as the therapist has to be aware of his or her reactions towards more than one patient at the same time.

> I have found that countertransference reactions engendered in couples therapy are more potent, complex, chaotic, and unruly than those activated in individual treatment . . . . Being in the middle of a ferocious fight provokes far more intense reactions than hearing about the fight in individual therapy.
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> (Sharpe, 1997, p. 40)

Monitoring countertransference responses can be complicated, but is very necessary if the therapist is to keep afloat in a sea of continuous waves: am I identifying with the struggles of both partners and entering into each of their inner worlds? Or am I feeling more of an affiliation with one and seeing their perception of the "bad" other as accurate? Do I admire/idealize one partner or both? Does one partner remind me of a parent or sibling? Is this relationship better than mine? Am

I sexually attracted to either partner? Am I overly curious or not curious enough about their intimate life together? Am I worried about what they think about me? Do I prepare for their sessions differently from usual? Do I regret, or am I particularly proud of, my participation after they have left? Considering that a countertransference-based interpretation is the most potent therapeutic tool we have, should any of these feelings or fantasies be deliberately disclosed to the couple? The answer to this last question is: rarely, but probably more often than in individual therapy.

If therapists remain unaware of their reactions to a couple, their inappropriate responses can include being chronically late for sessions, constantly putting the same spouse (often the rival) on the spot, ignoring the couple's blatantly provocative statements or behaviour (Guttman, 1982) or even finding a way of prematurely terminating the case. Like transferences, countertransferences are fluid and can change and shift at different stages of the therapy.

Often, therapists find themselves forced into either a parental or a child role with respect to the couple. We have seen earlier that the therapist as parent/teacher to the two "kids" is a common dynamic in this therapeutic triad. For some therapists, this can be a gratifying role as it enables one to be the loving and wise parent to squabbling siblings in, sometimes, a more effective manner than one has been able to accomplish in one's own life. The feeling of being competed for is also gratifying for some therapists; others, however, may find this intimidating. Younger therapists may find it difficult to be parentified, particularly with a couple who are older, and this evokes for them, as it does for all of us in some way, unsettled oedipal issues.

The therapist as child, looking in on the oedipal couple, often triggers a powerful form of countertransference. Feeling excluded from the couple's marital bed and their private space, the therapist may use the voyeuristic aspects of the therapy as a way of gaining admittance into the relationship, or may need to have themselves included by becoming indispensable to the couple. Frank (1997), mentioned earlier, openly describes

a case where he saw a couple in treatment as more unhappy than they actually were, and interprets his perception as a defence against his anxiety about being excluded from their intimacy, protecting himself from jealousy and envy.

In the role of child, the therapist may have a tendency to see all the pathology in one partner, corresponding to his or her view of different-sex parents. In addition, the experience of being a helpless child with fighting parents can arouse feelings of being overwhelmed and powerless when treating an argumentative couple; having the opportunity to repair the parental marriage, now seen through the eyes of a professional adult, can be so appealing that therapeutic zeal may actually get in the way, particularly if it is better for a couple to separate.

Envy, often seen as insidious and destructive, may be particularly virulent in the countertransference when treating couples, again because of the link to the oedipal couple. Even though we know that many of the emotions connected with idealization, avoidance, devaluation, and contempt are rooted in envy, envy of patients is considered almost shameful. Therefore, there is not much in the literature about the arousal of envy in the countertransference. The unconscious nature of most envious feelings may also account for the paucity of writing.

In work with couples, there may be much to envy. Feelings like "I wish I could have what he's giving her," or "I would be nicer to him than that," can easily be stirred up as we watch couples interact (West and Schain-West, 1997). West and Schain-West also enumerate many patient qualities of which a therapist can be envious, including youth, beauty, wealth, children, ability to love and be loved, ability to be carefree, or even to stand up for him- or herself. As a non-medical practitioner working in a province in Canada where the fees of medical practitioners are completely covered by government insurance, I am often in the position of seeing only those patients who can afford to pay a private fee for long-term treatment; these couples are often financially better off than I am. Therefore, when I hear arguments about whose turn it is

to remove the swimming-pool cover, for example, I may feel a twinge or two. I am also aware, perhaps in a rush of grandiose delusion, of being envious of the couple for having me – an attuned, reliably available therapist, who is interested in them and their problems and wants very much to help their relationship be more satisfying. Their entitlement to this is something I might not indulge for myself.

Of course, like all countertransference feelings, feelings of envy can be obstructive or productive. Envy of a couple's sexual activity, for example, can blind a therapist to underlying issues, such as their using sex as a defence against intimacy and closeness. Empathic listening may be impaired, as may the validation of a partner's ideas or interventions in the therapeutic process – especially if they sound better than the therapist's. Mingling of unconscious envy with a conscious desire to be helpful can lead the therapist to feel confused or ambivalent about the treatment. A therapist's need to be needed by the couple, and then feeling sad and left out when no longer needed, may lead to an envious sabotage of the couple's progress together. As West and Schain-West (1997) have said, couples as patients can often kindle awareness of our own missed or misused opportunities in life, as well as opportunities that we will never have.

Following are examples of countertransference with couples.

"Positive" countertransference

Anne and Michael, the lawyers who work together, have been introduced to the reader earlier in Chapter 1. I described there how I had acted as a container for Michael's anger – their presenting problem – in the sessions, thus attempting to detoxify it for both him and Anne. They had been referred to me by Anne's family doctor, after she had burst into tears about their marriage during a physical examination.

I am going to select one part of their treatment because it touched me so deeply that I felt at once sad, grateful, guilty, and overly competent.

About six weeks into our work together, Michael disclosed that he had been diagnosed with hepatitis C about one year ago. It had apparently gone undetected for twenty-five years, having been acquired through contact with a dirty needle during a one-time use of injectable drugs in his early twenties. When we first discussed it in the session, in addition to reporting their shock at the diagnosis, they both described a subsequent event that had been traumatic for them. This event had occurred as a result of a liver biopsy, part of the diagnostic procedure, which had gone wrong, unknown to them. A few days after this procedure, they had taken their son to Rome for the school break. On the second night there, Michael had become violently ill and had to be admitted to hospital, where he had surgery and remained, close to death, for about one month. Of course there were many repercussions to this critical incident, but one that they now needed to discuss was Anne's inability to comfort Michael during that time, as he was delusional and very angry. He was finally transferred back to hospital in Toronto and recovered slowly. The telling of this event and the resultant guarded prognosis for Michael's illness paralleled a critical incident in my life.

This couple came to see me exactly two months after the death of my own analyst, who died while I was still in analysis. He had been suddenly diagnosed with stage IV cancer, with both bone and brain metastases. He had informed me of the illness and its prognosis as soon as he knew about it. I then had colluded with him in not discussing it any further, despite noticing marked decay in his physical appearance as time went on, as well as a personality change, probably attributable to the brain involvement. The denial suited us both, at least in the beginning. His illness progressed rapidly: three months after the diagnosis, I received a telephone call from him saying that he had been advised to close his practice. We met for one last horrible time.

During the remaining time until his death two months later, he (and his wife) did not want any contact with analysands – no phone calls, cards, or email. Thus, information on his condition was hard to come by, except for the odd bits

garnered from colleagues, all of whom were so excruciatingly aware of possible transference issues that they avoided saying much – or even giving support. Galatzer-Levy (2004) has written an excellent article on this subject.

Therefore, when Michael began talking about his fear of dying from hepatitis C, I was, admittedly, countertransferentially challenged. Here was an opportunity to be an integral part of a couple's process regarding serious illness and possible dying, to be informed about their feelings every step of the way, and – maybe – to be of help to them, a role I was prevented from having in my own situation with my analyst. The subject was naturally very hard for both of them to discuss, especially in the light of their serious marital difficulties which had caused them to consider separation, and which were, of course, complicated by this relatively recent diagnosis. They had talked to no one about it: ageing parents were considered too vulnerable, and friends were hard to trust as they feared that if the word got out, they would lose their clients and the firm would collapse. They had not been able to communicate with each other about it since the Rome fiasco.

During the early months of our time together, whenever this subject came up, which varied in frequency, Anne cried and Michael became angry, partly in response to her tears. We spent many sessions on the month of illness in Italy, where Anne said Michael severely rejected her after the surgery. Michael had no memory of this, but apparently had behaved so badly that it was hard for her to forgive. I spent some time with Anne on her resentment at having a sick husband, which was not allowed to be acknowledged because of Michael's potential rage and also because, in quieter moments, Michael admitted that he felt guilty for bringing this on his family and himself. During these early times, I tried to get across to them the traumatic effect of the illness, saying it had been too much to handle. This seemed like news to them at first; later, they began referring to it as "the trauma."

Anne then brought in a dream:

> I was on a bus carrying a large turtle. It had a soft shell with a big hole down it as if someone stepped on it with high heels. I was responsible for taking care of it. It was squirming around in my lap. I was having trouble.

Anne quickly declared that she had no associations to the dream. Michael said: "The turtle is me. But you're not responsible for me – don't worry." My understanding of this combination of the dream and the lack of associations to it was that Anne was still very uncomfortable communicating directly anything about Michael's illness that might be construed as negative. Our discussion about this led to Michael's increasing ability to see the effect of his illness and his attitude about it on her.

In one session, Anne complained that when Michael had first learned of his diagnosis, he told her in the hospital parking lot that he had "six years to live." She found this aggressive and hurtful. I asked if he had wanted to hurt her; he wasn't sure. I said that when people think they are dying, they may feel angry at or envious of others who are healthy, and who have no idea what it's like to be in their situation. Both of them looked at me with rapt attention. Michael agreed; then, trying to be empathic and to soften his anger, said: "Of course it'll be hard for Anne when I die because I'm not there and she has to deal with the firm and our son." I said, somewhat mockingly, "Yah. It's easy for *you*." He laughed hard, as did Anne through her tears.

As the sessions went on, and they described in detail their anxieties, my need to be included in this horrendous process with a couple was getting so easily met, I hardly noticed it. After several months of our work together, Michael was scheduled to have a blood test which would indicate whether two years of a chemical drug treatment had had an effect on the hepatitis C. Before he was to meet with the doctor, Anne, who was going along to the appointment, came to the session with a pad and pen, asking if we could formulate what questions to ask. Her contention was that Michael was too cavalier with the doctors and didn't press them enough; he

described her as "lobbing grenades" at them. We worked through questions that were comfortable for both. I must have looked very concerned at this point, because Michael, uncharacteristically, leaned over toward me and said: "Don't worry. It's going to be all right." (*Great*, I thought, *now I've got him, in the analyst-transference, looking after me.*)

The news from the doctor was mixed; liver function was stable, but the virus was still there. In terms of the six years pronouncement, they now were not sure; cures might well be discovered sooner than that and since Michael felt relatively well, he might be expected to live much longer. Anne started to feel panicky again, and asked me what people do in this situation. (*I wish I knew*, I thought.) I advised them to put as much of the practical stuff in order as they could, and then to live their lives. They talked about their wills, the firm, and their son. I was by now startlingly aware of my interest in being part of the real nuts and bolts of this process.

In the next session, Michael brought in a work problem which we discussed energetically. Then, Anne started the following session by saying she felt guilty about that previous session. I interpreted to them that we had *all* engaged in a flight, to get some relief from the business of sickness and possible dying. Subsequently, Michael became much less angry and was more able to talk directly to Anne, to reassure her that he felt better and that he wanted to take better care of himself physically.

There was still a lot of emotion in our sessions, and they still fought about their business problems. Also, Michael's anger, at least that part of it that was not directly related to the illness, although less and less frequent, was still erupting on occasion and remained an issue for Anne. In one session, Anne, in her sensible way, made the following statements, which Michael and I, impressed, immediately acceded to. She said she wanted to map out what they had been through in the last nine months – his chemo treatment, the prognosis, and the business and marriage problems, and think now about starting a "new landscape." "Michael has a chronic illness, and needs to take care of his general health," she said.

"We are overly busy at work and need to spend more family time. We need to move forward on this new landscape. Something may happen where we'll step off the landscape, but then we can get back on."

That spring there was an opportunity for a family trip to Rome, and Michael seized it. In the session after they returned, he described going back to the hospital where he had almost died exactly two years before. He visited the ward and his room – "someone else was in it." He said he didn't feel sad, he felt it was really over. He had planned to sit and read a book on the same bench in the hospital garden where he used to sit, but some nurses were practising for a fire drill and he couldn't concentrate. None of the doctors and nurses that he had known were there. "They had probably been promoted," he said, indirectly showing his gratitude.

"*Talk about working through*," I wrote in my notes. "*I am constantly impressed by how quickly and deeply both of them get this – particularly M. who started out so defensive and angry. I feel we are doing such good work, particularly – maybe only? – around the whole possible death issue. I hope I'll now be able to let them move on to other issues.*"

"Negative" countertransference

Unfortunately, as we would expect, the countertransference is not all roses and loving parenting, despite the therapist's conscious need to be all things to all people. I have been in situations where I have had a negative countertransference response to one or both partners in the couple, and have found myself wishing that the therapy would not "work," i.e. that the couple would break up!

In one situation, Lara, the young wife, was, for want of a better descriptor, a gold-digger. Allan, the financially successful husband, had been in one failed marriage, and very much wanted this marriage to work. They lived in a beautiful home and had a full-time nanny for their 8-year-old daughter, despite the fact that Lara was at home. In their courtship, Lara had portrayed herself as an indigent waif, needing

rescuing, which captured Allan's imagination, as well as his character pathology. Now she came to therapy complaining that he wouldn't give her enough money. Catching the glare of her diamond ring, which must have been at least 2 carats (see the section on "countertransference envy"), and being oppressed by her appearance in sessions so inappropriately over-dressed, I began to feel like the poor maid-servant. "Why doesn't he see it?" I kept asking myself about Allan. "He's aggressive at the office, but he lets her walk all over him at home."

As the therapy went on, and Allan began reporting rather compliantly that things were much better between them, I may have winced noticeably. Lara, who stated that she really wanted the marriage to last (although she had seen a lawyer regarding her financial rights), began trying to enlist my favour by making female-to-female comments – for example, "Can you believe he gave his ex-wife a key to our house?" – and when I raised an eyebrow, said to Allan, "See, all women react the same way I do." Since I really don't like the game of *gotcha*, especially when I am the one gotten, this heightened my negative response to her, which, by now, I had stopped trying to connect to my past (when my family had less money than many of my friends' families). I tried instead to determine what Allan wanted, and why he could not articulate what he wanted to Lara, relating it to his early relationship with a critical and domineering father, whom he could never please. In this couple, Allan seemed to be the partner most interested in understanding what had happened to make this relationship stop working; Lara *seemed* to be learning by listening and observing. Since they both wanted the relationship to work (and I was the one with the discrepant agenda), we worked at negotiating what they needed from each other in a fairly unemotional manner that made sense to both of them.

In another situation, the couple had been ordered by the court to come for therapy after the husband, Leo, an office manager, had beaten his wife, Fiona, a physician, so badly that she went to the Emergency Room of a nearby hospital

where they encouraged her to press charges. As a result, he was forced to live separately from her until his trial, which was about one year away. Issues of bullying get to me. My countertransference response began with the initial telephone call, and I considered referring them to someone else; still, the challenge of taking on a bully from a position of relative power, and maybe even precipitating some change, was one I could not bring myself to turn down.

Leo was all I had imagined him to be, and much more. He showed little remorse for his actions and, in fact, blamed Fiona for provoking him by not answering her cellphone when he called. This was not the first time he had hit her, but it was the worst time. Leo described their fight over the cellphone as though he had been the wronged one. Added to this was his indignation over the ensuing enforced isolation from her, more rent to pay for a separate apartment, a bleeding ulcer that had erupted "because of her," and the possibility of a jail term that would wreck both their lives. It was difficult to get a rapport with these two, and indeed, if they hadn't been in therapy at gunpoint, so to speak, I probably would not have managed it.

Leo and Fiona were both of Middle Eastern background, and had many friends and cultural interests in common. Leo, who was ten years older than Fiona, was the acknowledged expert on music, art, home decorating, in fact, all dimensions of their lives together. When they started therapy, Fiona was certain that the whole episode of the cellphone was her fault and that she should not have reported him; she cringed in submission whenever Leo spoke. The tyrant–supplicant dynamic was a tough one to ease off. Fiona had been in this type of relationship with an intruding and over-controlling mother, who told her what to do in every aspect of her life and she had obeyed – except her mother did not approve of Leo. Leo easily took over the mother's role, and fought so much with Fiona's mother, that it was agreed (by both Leo and Fiona) that her mother was not allowed in their house, and was not even allowed to telephone on their home phone; hence the acquisition of a cellphone.

Interpretations of the dynamics between them revolved around Leo's contempt for his own felt "weakness" and masochistic tendencies which he had projected onto Fiona, and Fiona's need to maintain the status quo – all of these observations were, of course, delivered very cautiously and slowly. My comments were usually met with interest by Fiona and bored resistance by Leo. Balancing airtime was difficult at first, but when, in one session, they brought me a cartoon of two kids fighting and then fought like two kids over who would get to show the cartoon to me, I began to realize how much each of them needed care in terms of their individual concerns: for Leo, it was his health; for Fiona, it was her being overworked.

After these concerns were identified, things went a little better and they began to trust me more, and described in detail fights over shopping, cooking, and many other facets of their lives. In all of them, Leo would become extremely impatient with Fiona, and either mock her or yell. There were many times when, to gratify my own countertransference needs, I directed statements to Leo on Fiona's behalf, indicating that his behaviour was inappropriate, and role modelling some arguing strategies with him. I found myself saying things to him that I knew Fiona could not say. When this happened, Fiona could hardly keep from applauding which, of course, I was keenly aware of. "Finally things are getting said!" she declared. Leo seemed to have met his match, and was even able to start to think of himself as a "bully." Fiona was amazed that someone could engage Leo in this manner (albeit in confined circumstances) and became emboldened herself. She began to yell back at him, and then would look at me and laugh like a scared child – as if to say, "Is this really OK?" Getting her to talk rather than yell was not too hard from there. When they both realized that this was a way to gain approval, even Leo seemed to be learning something, and they took to arguing with each other with me observing, watching for my reaction; they then were able to negotiate more effectively at home and report back to me about it.

Here was an example where my overidentification in the countertransference was made somewhat useful by emboldening a patient in the way I wished I could have been emboldened in my own early life. It also confirmed for me a disidentification with bullies, as well as a taming of them. This couple stayed in treatment past their mandated time. One of the outcomes of their therapy was that Fiona developed a close friendship with another woman, and really enjoyed her company – shopping, going to movies, having coffee out. She had not had a close friend before. I saw this as an externalization of the transference, made possible because she had finally felt validated.

Using the countertransference

The therapist's ability to conceive of a triangular relationship, rather than a dyadic one – in other words, the therapist's own stage of developmental achievement – will contribute to the ease with which they will be able to work with couples. As can be seen, therapy with couples evokes intense countertransference feelings and fantasies. The pre-oedipal needs of some couples to have an all-giving, all-nurturing mother with whom to merge, as they try to do with each other, can evoke feelings of bliss in the therapist, or feelings of intrusion and annoyance. As we have seen, the oedipal countertransference constitutes a reactivation of the therapist's own oedipal experience and unresolved longings.

> In reexperiencing the oedipal child's central conflict, the therapist typically shifts back and forth from idealizing the couple as a parental unit (in the wish to sustain both partners' love) to the oedipal idealization of one partner (including the wish to win that partner away from the other). It is the positive oedipal constellation that is most strongly evoked.
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> (Sharpe, 1997, p. 65)

Although an absolutely even-handed empathic approach is extremely difficult – and trying to effect a blank screen in couples therapy seems impossible – most couples therapists work hard at balancing airtime, and at making a conscious effort to avoid identification with, or wooing of, one partner. In my experience, as was noted earlier, countertransferences and identifications are fluid during the process of the therapy, if one is open to noticing this. As the therapist gets to know each individual more deeply, it is usually difficult to maintain a desirable–undesirable split in the partners in the countertransference.

Boundary setting is more difficult, and just as important, in couples therapy as in individual therapy. The therapist's good nature is imposed upon by two people asking for special consideration, including telephone calls and individual meetings. Some of this behaviour is predictable, and interpretable, from the patients' histories; some, when presented urgently from an admired patient and not predicted, appeals to the therapist's grandiosity and unconscious need for an oedipal victory, and may be hard to turn down.

As McLaughlin (1991) said, there are always plenty of "dumb spots, blind spots, and hard spots" to be navigated for the individual therapist. The couples therapist's behaviour and personality seem more in evidence, and therefore their countertransference reactions are more transparent, than those of the individual therapist. There are many subtle communications of our countertransference – in the way we listen, whom we face more often, whom we address or smile at more frequently, our expressions of interest or lack thereof – that are conveyed every moment and usually picked up, consciously or unconsciously, by one or both partners. Acknowledgement of these reactions is always helpful. The therapist can then analyse, privately, whether these observations feel "accurate," and whether they indicate a dynamic between the partners or between the partners and the therapist that would be worth commenting on.

As has been mentioned earlier, the therapeutic triad is ripe for projective identifications, probably in all directions. Being

provoked to accept feelings and roles that pertain directly to the partners' internal object relations can be a source of countertransference confusion and anxiety. However, it is also an amazing source of information: as therapists struggle with their own internal responses, they become aware of getting a sense of each individual's dynamics and of what the couple do to each other. Sandler's (1976) concept of the therapist's free-floating responsiveness is a necessary, though difficult, condition for this type of work.

In many ways, making use of the countertransference with a couple may be easier than it is in individual therapy. Although a lot has been said about the opportunities for power in the therapist, there is also the chance that the therapist's pearls of wisdom may be significantly diluted by the couple, either because of sheer numbers, or because partners can react against them or dismiss them outside of the session when they are alone together. Because of this, and because there is always a witness to what I say, I communicate my countertransference reactions more frequently (sometimes) with couples than I do with individuals (just about never). For example, I told Fiona and Leo that I often feel like they are two kids fighting for my attention. I told Michael that I was impressed with how *he* had adapted to therapy and had come up with ideas for working through the trauma; I told Anne that I admired her ability to get perspective on issues, even though she feels so emotionally overwhelmed at times. I told Nick and Mirella that I, too, was stuck in getting an understanding of why they fight so much. All of these comments seemed to be taken in a way that advanced the work, which I see as the only reason to disclose countertransference reactions.

Using one's countertransference to help expand understanding and empathy, and to give partners valuable information about themselves and each other – when done consciously and deliberately, or analysed with or without the couple in retrospect – can make the treatment even more lively and current. Being a container for denied and disavowed aspects of one's patient(s) is not always a bad thing.

I want to say a few more words about the gender of the therapist, elaborating on my comments in the previous chapter. I am aware I have sometimes used the sexist term "mother" for parent, and have reported a female perspective on transference and countertransference issues. Besides the obvious reason for this, I would also like to point out that much of the recent analytically-oriented couples therapy literature has been written by women (e.g. Solomon and Siegel, 1997; Sharpe, 2000), although a significant amount of the earlier work has been done by male therapists (e.g. Dicks, 1967; Ruszczynski, 1993). Even the *New Yorker* cartoons picture female therapists for this type of work (and usually male therapists for individual therapy).

Countertransferences in male couples therapists will be different from those of female therapists; certainly, a couple must react differently to a male therapist and males must react differently to the oedipal triadic setting of couples therapy. However, the differences may not be as great as they would seem at first blush. In addition, gay or straight therapists treating gay or lesbian couples might encounter somewhat differing transferences and countertransferences. Hopefully these limitations of this book will continue to be rectified by other writers.

Chapter 7

Dénouement: working through and termination

The analytic literature on the processes of working through and termination describes the complex emotional responses that the latter, particularly, evokes in therapist and patient alike. As the reader might now expect, these processes are even more complex when they are happening with two patients at the same time.

Working through, which "permits the subject to pass from rejection [of an interpretation] or merely intellectual acceptance to a conviction based on lived experience" (Laplanche and Pontalis, 1973, p. 488), does not happen quickly, as we know from individual treatment. Despite what the movies tell us, patients rarely have an "aha" experience – exclaiming "Oh thank you, Doctor, now all is clear!" – and even more rarely do they proceed to change their behaviour if they do. Resistance to change is the most likely sequela to insight, as people are attached to their past familiar ways of relating, and even to their symptoms. In couples therapy, when a dysfunctional pattern has been identified, several interesting possibilities arise. One partner may want a change and try to move the interaction in that direction; the other, however, may see any change as threatening the relationship and therefore hang on more tightly. If the interpretation or observation originates with one of the partners, rather than with the therapist, it may be accepted more easily, because of the lack of authority-loading, or less easily, because of resentment of the other. What makes the working through more difficult with couples is that the behaviour is usually