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TOLERATING THE COUNTERTRANSFERENCE: A MUTATIVE PROCESS

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Much has been written about the countertransference in the more recent psychoanalytic literature. In this paper I shall look at the patient who evokes intense feelings in the analyst. I shall discuss the basis of such a phenomenon and different possible ways of dealing with it, and I shall describe how 'tolerating' the countertransference can be of therapeutic benefit to the patient.

I shall begin, however, with a few historical comments on the concept of countertransference.

It is often said that although Freud changed his views about transference from seeing it as a hindrance to appreciating its central therapeutic value, he never realized the therapeutic value of countertransference. In fact, what we now refer to as countertransference, and regard as helpful, is a different phenomenon from that described by Freud using the same term.

Freud first used the term in 1910 to refer to the analyst's unconscious resistance against freely helping the patient to deal with areas of psychopathology which the analyst himself found difficult, and he maintained this usage throughout his later writings. What we call countertransference nowadays is quite different, the term being most commonly applied to conscious and preconscious *feelings* which the analyst has towards his patient.

The move towards this more modern version was begun by Paula Heimann in her 1950 paper 'On countertransference'. She starts by defining the term as 'all the feelings which the analyst experiences towards his patient'. She includes the unconscious in this, describing the countertransference as being the result of an interaction whereby 'the analyst's unconscious understands that of his patient', but she focuses in the paper on conscious and preconscious feelings—what she calls the analyst's 'emotional response' to the patient. It is this focus on conscious and preconscious feelings towards the patient which has come to be generally referred to in more recent years. Segal (1977), however, has pointed out that, contrary to this common usage, the major part of the countertransference is unconscious, and we become aware only of its conscious derivatives.

Heimann goes on to describe how, if the analyst allows himself to become aware of his countertransference, the feelings can be used to point him towards the areas that are significant to the patient at that time. The process whereby such a situation becomes possible can be understood through the concept of projective identification, which was first described by Melanie Klein (1946) as a mental activity occurring initially in early infancy, but continuing throughout life. It is based upon an unconscious phantasy in which split off parts of the self are seen as having been put into, and become part of, the other person, originally the breast as a part-object. This original concept has since been extended by Bion (1959) and Rosenfeld (1971) to include the notion that the recipient of the projective identification is affected by it, such that he can experience whatever is projected into him. It is on the basis of such an idea that the later views of countertransference are now understood, and it is interesting that Heimann says in 1950 that 'the analyst's countertransference is not only part and parcel of the analytic relationship, but it is the patient's *creation*, it is a part of the patient's personality'.

Writings on this subject are unclear as to exactly how the analyst's mind is affected in this way. In discussion of clinical material, analysts sometimes talk as if they believe that this aspect of the countertransference involves the analyst actually feeling the *patient*'s feelings, in a concrete sense—as if feelings leave the patient's mind and are inserted into the analyst's mind.

I think that the confusion about this arises in part from writings on the subject which are describing thoughts or phantasies existing in the mind of a patient, or baby, or analyst, or mother, but which fail to spell this out clearly, and so can give the impression that they are describing phenomena from the point of view of the writer, or any other objective third party observing the interaction being described. For example, take my last quotation from Heimann who says that 'countertransference ... is a part of the patient's personality'. The patient might well believe, as part of his unconscious phantasy, that this is concretely the case. Likewise, the analyst might, thus conceptualize the situation if he has read (or misread) the relevant literature. But, in my opinion, a hypothetical objective observer of the interaction would see that both were mistaken in their beliefs, and that the patient somehow had been able to *induce* in the analyst a state of mind very similar to one he was more or less successfully attempting to eliminate in himself.

Projective identification is a primitive phenomenon and can therefore involve very powerful feelings which are only able to be dealt with in this way because the patient is unable to put them into words. Particularly with more disturbed and borderline patients, the analyst finds himself filled with powerful feelings in the session, and is faced with the problem of how to deal with them. The first difficulty is described by Heimann (1950) when she points out that 'violent emotions of any kind, of love or hate, helpfulness or anger, impel towards action rather than towards contemplation and blur a person's capacity to observe and weigh the evidence correctly'. The danger is that the analyst will act out his powerful feelings, and his first task in such a situation is to attempt to tolerate these feelings, without acting them out. I shall return to an examination of this area later.

With a more subtle countertransference, the first task is often simply to recognize these feelings, but this can be difficult, as is pointed out by Brenman Pick (1985). She reminds us that the analyst is a human being, and is therefore as likely as the patient is to wish to avoid the pain of the projected experience.

She also talks about the analyst's next task. Having recognized his countertransference feelings, and having avoided acting them out in a destructive manner, the analyst must attempt to undo the inevitable tangle in his mind between what is more directly patient-produced, and what is more a function of his own personal response to that production. If he can do this the analyst can then try to understand what the patient is projecting, along with the motive behind it.

All this is fairly generally agreed, but we now come to a difficult problem. How is the analyst to utilize what he has learned to best therapeutic advantage?

There are those who have advocated that the analyst should reveal his countertransference openly to the patient, in a variation of 'You make me feel such-and-such'. In a follow-up to her 1950 paper, Heimann (1960) states that 'a communication of this kind represents a confession of personal matters pertaining to the analyst, and would mean a burden to the patient and lead away from the analysis. Therefore it should not occur' (p. 12). I would add that since the patient projects something he is unable to tolerate, he is likely to experience such a 'confession' as confirmatory evidence that his projection is intolerable, since the analyst is having to get rid of it also.

The idea has been formulated, principally through the work of Bion (1962a, 1963), that through a process of understanding the patient's projections, the analyst functions as a 'container' of them, such that they are 'detoxified'. That is to say that the frightening and distressing nature of what the patient projects is mitigated, and the analyst then has to find a way of conveying the projected part of the patient back to him in an acceptable form. This is done by interpretation, which allows the patient to take back in, re-introject, the parts of himself he has projected, but altered such that they can be integrated into his personality.

The extent to which this is possible varies greatly. The situation is addressed by Rosenfeld

(1971) who describes such interpretations as being the essence of the analytical task in instances where the patient is using projective identification as a communication. He says that here the patient is receptive to the analyst's understanding and can find the interpretation meaningful. Where projective identification is being used, however, to deny psychic reality, interpretation may be experienced as a forced re-entry. Rosenfeld says it is important to differentiate these situations in order to keep contact with the patient and make analysis possible.

Another way to look at this is to consider the extent to which a patient retains within himself some vague awareness of whatever is projected. The more a patient retains an awareness of what he projects, the more he will be able to recognize it as *his* when the analyst interprets it to him. A more disturbed and borderline patient tends to use projective identification in a more complete form, so that he often divests himself entirely of his projection, seeing it as entirely foreign to himself, and retaining no awareness of it whatsoever. It is here that the therapeutic task is rendered particularly difficult, and it is this situation which I principally address in this paper.

The first point I wish to make is that in such a situation it is worse than useless for the analyst to try to tell a patient he feels something he simply does not feel. The patient is further convinced of the reality of his projection by a confirmation that what is intolerable or unacceptable does indeed lie elsewhere. Furthermore, the patient feels himself to be confronted by an analyst who is attempting to push something frightening or crazy into him.

There do seem to be analysts who insist upon using the countertransference in this way, apparently in the belief that although the patient is not aware of feeling what he is being told he feels, the interpretation will somehow affect him at a deeper level. I think that this carries the risk of a pseudo-acceptance of such an interpretation, motivated by fear of a frightening analyst, which is hidden behind an idealization of the analyst (and his technique). Certainly Rosenfeld (1971) appears to warn against such a technique. He recognizes the technical problem, and seems to suggest that the best approach is to interpret the projective process as well as the content of the projection. This presumably involves telling the patient that he *avoids* feeling such-and-such through a belief that he has got rid of such feelings into the analyst, and this also is a technique used by many. Once again, however, it involves telling the patient he feels something which he is unaware of feeling, since the phantasy of projective identification being thus spelled out by the analyst is, by its nature, unconscious and unavailable to the patient. In my own clinical work I have not found this approach useful, although Rosenfeld is describing work with psychotic patients, who may well be more aware of their phantasies than the less seriously disturbed.

We are left with the question of how to deal with powerful experiences in the countertransference to best therapeutic effect. I am suggesting in this paper that if the analyst is able to tolerate such feelings, then this by itself can help the patient, and produce psychic change. I shall explain what I mean by the word 'tolerate'. I am not referring to an ability to remain unaffected by the patient's projections, or to distance oneself from the heat of the emotional interaction, or to 'hide' one's emotional response from the patient. An analyst who responds in these ways is likely to be experienced by the patient as distant, or cut-off, or frightened, or insincere. What I do refer to is the ability to allow oneself to experience the patient's projections in their full force, and yet be able to avoid acting them out in a gross way. To do this, one must be able to avoid being taken over completely by the experience, but I believe it is *inevitable* that if the projections are fully experienced, then the countertransference will be acted out to some partial degree. Brenman Pick (1985) says as much when she describes how projective identification is intended to produce *reaction*, which may be dealt with so quickly as to be unrecognized. 'The analyst has an impulse to enact, and some of this will be expressed in the interpretation' (p. 158).

I think that this acting out can take many forms, including choice of the area of interpretation, the type of interpretation and its wording, and the tone of voice in which it is delivered. I believe that this unavoidable aspect of the situation is, in the end, of positive therapeutic value, and later I shall give an account of how this

might be the case, but firstly I give a clinical example illustrating the partial acting out to which I refer.

The patient is a single woman in her mid-30s, seen in once weekly psychoanalytic psychotherapy. Her complaint is of phobic and obsessional symptoms. She is unable to use elevators, or travel on the Underground or in an aeroplane, describing a fear of becoming 'stuck' in these situations, although no such thing has ever actually happened to her. She worries constantly about her parents' health, particularly fearing that her father will suffer another serious nosebleed and die. This also extends to her own health and she is a frequent attender at the doctor's surgery with minor ailments. She is obsessionally neat and tidy, and will constantly rearrange the clothes in her wardrobe, or items at work. Before retiring for the night, she has to check repeatedly that the doors and windows are locked, fearing intruders. Eating out is also a problem, due to a fear of eating food which has gone 'off'. At home she constantly smells food before eating it, and discards any which has passed the recommended 'sell by' date on the package. She is unable to eat in restaurants.

She is the only child of Spanish working-class parents, and remains closely tied to them. She lived with them at home until her early 30s, and only left to live in her own flat to escape her fear that her father might have a nosebleed during the night and she would have to attend to him. Despite moving away, she spends evenings and weekends at her parents', really only using her own flat as a place to sleep. Mother is described as soft and calm, and father as harder, and liable to panic attacks.

She left school without qualifications, worked in a clothes shop, and finally opened her own small shop along with a female partner, selling ladies' clothes.

At her assessment interviews, she was described as being controlled and businesslike, displaying no emotions at all. One striking thing about her was that she had no memories of any sort before the age of 16. She was also unable to describe any dreams or phantasies and gave the impression of having a very empty inner world. She had a couple of girlfriends but had never had a lasting relationship with a man. She described her emotional state as being on a constant 'even keel—neither up nor down'. She did admit that she would sometimes get angry with her parents, and described an incident where she had had an argument with her mother. Mother subsequently offered to cook the patient a meal, which she refused, saying she was not hungry, but she then proceeded to eat a slice of dry bread in front of her mother. This was described in a characteristically factual and affectless manner, as if she was entirely unaware of having felt anything at all at the time.

She began once-weekly treatment with me after a lengthy wait for a vacancy. In the therapy she presented in a very practical, businesslike manner, with an attitude that she was a patient, coming to see a doctor for a course of treatment designed to help her with her phobic symptoms. She greeted me with a 'Good afternoon, Doctor', and left with 'Goodbye, Doctor'. During the sessions she was co-operative and friendly, showing no other emotion, talking constantly such that I found it difficult to speak, and referring occasionally to her dislike of silence.

I quickly discovered that any attempt by me to interpret the transference would be met with an innocent, surprised bewilderment. She could not understand why I was suggesting that she should have any feelings about *me* when, after all, I was simply the doctor she was coming to for help with her symptoms. An example of this attitude was where, after several months of therapy, she asked for a change of her regular time because of a work commitment, and when I was unable to accommodate her, politely asked me whether I could arrange for her to transfer to another doctor. Almost every comment which I made to her was carefully and politely examined and shown to be invalid, either on sensible, rational grounds, or because I had used a word in describing something which was different from the word she had used. I tried to interpret this as involving her fear of taking in something bad, like the 'off' food, but to no avail.

My countertransference throughout many of the sessions was an overwhelming feeling of impotent rage that I was being dismissed as useless and unimportant along with my attempts to help her. I feel that this derived from a projective identification of similar feelings in *her*, and that for such an effective evacuation of these feelings to take place into me, it was

necessary for me to be a suitable container for them. That is to say that I myself must be significantly susceptible to such feelings on my own account for such a successfully massive 'transfer' of them to have taken place.

At various times earlier in the therapy, I tried to talk to her about her feeling useless, or resentful towards me, or her wish to control me and prevent me from helping her, but these comments were totally meaningless to her. I realized I was not helping her in this way, so I tried to avoid such interpretations and simply to tolerate this countertransference. This does not mean that I stopped interpreting. I continued to attempt to interpret the nature of the transference as I saw it, but I paid particular attention to the need to avoid interpretations which she might be unlikely to accept. I think that attention to this endeavour helped me to avoid acting out my countertransference in a *gross* manner; however, I shall now give an account of a session which took place about a year into the therapy and which I hope will demonstrate the continuing degree of partial acting out on my part.

She began the session breathless, as usual, having climbed up four flights of stairs to reach my room. She smiled and said, in her chatty way, that she was even more short of breath than usual today because she usually rests for a moment at the top of the stairs, but a man was standing waiting for the lift and she worried he would think there was something wrong with her so she did not wait. She had arrived in the waiting room earlier than usual today and had read in a magazine a story about a woman who was a heroin addict, having turned to drugs because she was depressed. The woman had not realized at the time that she was depressed, only noticing that she was taking less care of herself. Reading this story hadn't made the patient feel depressed, it just got to her a bit, that's all. On the bus coming here she was thinking about what she was going to talk about, and, as usual, couldn't think of anything important that had happened since last week. As I know, she doesn't do very much, just goes to work and then home again. She thought on the bus about last week's session and what had happened in it, though it hadn't crossed her mind all week. Thinking about it, she felt a bit down—not depressed. Reading about this drug addict made her think about how, over the past couple of years, *she* hasn't been taking quite so much care over things. It's not that she's allowing herself to go to the dogs or anything. There are just some things she tends to let go, especially in her flat where there are things she used to do every day or every week, but now it's every couple of days or weeks. Not that it's dirty, or that anyone else would notice. She doesn't have visitors anyway. If a friend comes to see her it's usually at her parents' house. She supposes that anyone else would think her flat looked OK, but *she's* aware that some things aren't being attended to properly.

The above is really a condensed account of the first half hour of the session, where she talked constantly such that I was given no opportunity to speak. At this point she paused slightly, allowing me to say to her that it sounded as if she had become aware of feeling a bit down inside, something she felt here last week. I added that she seemed to be saying that this was something other people wouldn't notice, something I was not noticing, so that it wasn't being attended to here.

Her response was to say that she doesn't see the point of attending to things. After all, one of her problems is that she attends to things too much, especially at work where everything has to be perfect. Her partner goes on about how she spends ages making everything neat and tidy—one of her obsessions. And, of course, none of that is any better. She's still coming up by the stairs.

I said it seemed that when I try to make an attempt to attend to her distressing feelings here, she goes on to talk about her symptoms.

She said she couldn't see the connexion. She was trying to think on the bus about how getting emotional about her parents dying and being left alone (an issue from the previous week) could have anything to do with her symptoms, and there's no connexion. At least none that she can see. Maybe I have some idea about it, but I haven't put it to her yet, although she presumes I'm a qualified psychiatrist, and must know what I'm doing.

I said it sounded as if she was able to 'think about' her distress and feel it wasn't connected to her symptoms, so there was no point in bothering about it. She was making it all neat

and tidy so that she didn't have to worry about it.

She said her parents are going to die eventually, and there's nothing anybody can do about that, so it's best just to put it out of her mind. Really she wants help with her symptoms, and maybe that just takes a very long time. She sees other people in the waiting room so she supposes people do get help here. Maybe it's just she that can't be helped, so I'd really be better seeing someone else.

I pointed out to her that she had been coming here for some time now and had seen that what seems to happen is that she talks about her symptoms and I say things about her feelings, which she now admits do cause her some distress. Yet what she seems to be saying is that she's not interested in having anything to do with her feelings and her distress; not interested in what I have to give her. She only wants help with her symptoms which are troublesome but don't seem to cause any distress, and she feels she's not getting any help. I added that it was like the situation with her mother, where she is hungry and her mother offers her a meal but, in her anger, she says she doesn't want it and deliberately eats dry bread in front of her mother.

No, she said, that's different, because she does that when she feels angry with her mother. She doesn't feel angry with me because there's no reason to. It's like if she goes to the doctor, she hopes the tablets will help, but if they don't she doesn't feel angry with him. She just feels it's something he can't help her with.

At this point we had run out of time, and I told her so. She commented that the time had passed quickly. I said I thought that was because she had felt so much on top of the situation. She smiled and said she thought I was right. 'Goodbye, Doctor.'

I think this session illustrates how the patient got under my skin, causing me to act out slightly by making comments which were critical and involved my trying to make her feel something she was unable to feel. What I took to be her triumph at the end resulted, I believe, from her having been able to observe that she had got to me and affected me in this way. Although I think she had a momentary conscious awareness of this, it seemed to have gone when I tried to refer to it in the following session.

This brings me towards the main point I am trying to make. The analyst's partial acting out allows the patient to see, consciously or unconsciously, that she is affecting the analyst and inducing strong feelings in him, and it allows her to observe him attempting to deal with these feelings.

This is somewhat at variance with the view put forward by Winnicott (1949) in his paper 'Hate in the counter-transference'. He says that 'the analyst must be prepared to bear strain without expecting the patient to know anything about what he is doing, perhaps over a long period of time... Eventually, he ought to be able to tell his patient what he has been through on the patient's behalf' (p. 72). He is not advocating that the analyst actively 'hides' his counter-transference, rather that the patient is incapable of an awareness of the analyst's hatred.

I do not believe this to be the case. Projective identification would not be a particularly useful mechanism to the patient if the phantasy was not supported by some sort of evidence that the patient's view of the world was a real and accurate one. I think that my experience with this patient is only one example of her lifelong, and perfectly honed, ability to get under people's skins in this way, and observe their frustration with her, while *she* remains devoid of feelings, and one can imagine such an aspect to the interaction she describes with her mother over refusing a meal and provocatively eating dry bread.

Brenman Pick (1985) suggests that the patient watches, consciously and unconsciously, to see if the analyst evades or meets difficult areas within the interaction. I would like to say, more specifically, that I believe it is the *inevitable* partial acting out of the countertransference which allows the patient to see that the analyst is being affected by what is projected, is struggling to tolerate it, and, if the analysis is to be effective, is managing sufficiently to maintain his analytic stance without grossly acting out.

I believe it is through this process that the patient is able gradually to re-introject the previously-intolerable aspects of himself that are involved. He also is able to introject the capacity to tolerate them which he has observed in the analyst.

I am saying, therefore, that in these circum-

stances it is the gradual process of introjection as a result of this non-verbal interaction which produces change in the patient's psychic structure, rather than an interpretation whose content is meaningless to the patient. The interpretation can only become meaningful *as a consequence of* the patient's discovery of aspects of himself through this gradual process. It is only then that the patient is able to recognize what he has projected as *his*, and so the 'successful' interpretation, and the sense of mutual understanding produced by it, serves as a confirmation of something which has already become available to be more consciously understood.

As in all good analytic work, the interpretation helps in the formation of a link in the patient's mind, in this case between preconscious and conscious. Projective identification is part of a mental scenario where links are destroyed because they cannot be tolerated. I think that in the interaction I have been describing, the analyst's tolerating the countertransference involves his making links in *his* mind, and it is this which allows the patient to do likewise.

It is difficult to think about such issues without speculating as to how they might be extrapolated into the mother-baby interaction.

Bion (1962b) writes about maternal reverie—a receptive state in which the mother is able to be aware of the bad parts of the infant which are projected into her. She acts as a container for these projections and modifies them through thought. She is then able to 'respond therapeutically'. This obviously does not mean that she gives the infant an interpretation. Bion explains that she responds 'in a manner that makes the infant feel it is receiving its frightened personality back again, but in a form that it can tolerate' (p. 115). He does not say exactly how this comes about. Nor does Rosenfeld (1971) when he tells us that 'the mother is able instinctively to respond by containing the infant's anxiety and alleviating it by her behaviour' (p. 117).

I am suggesting that the normal infant needs to be able to sense that his mother is struggling to tolerate his projected distress without major disruption of her maternal function. She will be unable to avoid giving the infant slight indications of the way she is affected by him, and it is these indications which allow the infant to see that the projected aspects of himself can indeed be tolerated. The infant is able then to re-introject these aspects of himself, along with the capacity to tolerate them which he has seen in his mother.

The paradigmatic situation referred to by Bion, is of the screaming hungry baby who feels he is dying. The *mother* becomes gripped by a panic that the infant is dying, and she will be unable to feed him quickly enough. If she is able to tolerate such a panic she will feed the baby. In my opinion, what is 'containing' about this is that the baby will have an experience of being fed by a mother in whom he can sense panic, but who is nevertheless able to give him milk. This is what makes the panic tolerable.

It follows from this that with a 'normal' baby the degree of 'acting out' by the mother is crucial. If it is more than minimal there will come a point at which the infant will experience the 'badness' of the panic to be more powerful than the 'goodness' of the milk. Instead of the milk making the panic tolerable, the opposite will happen, with pathological consequences.

Since the same is likely to be true of the analytic interaction, in no way do I advocate that the analyst should deliberately act out his countertransference. I feel, however, that previous descriptions of containment in mothers and analysts do not fully recognize the significance of our inability completely to contain whatever is projected into us, and it is this which I have been trying to address. I have focused on the more easily observable version of the phenomenon I describe, as it is found in the therapeutic interaction with more seriously disturbed patients. I believe, however, that a similar form of interaction is an aspect of the therapeutic relationship with all patients, and that it contributes to the therapeutic action of psychoanalysis.

Summary

The paper examines the technical problem of how to deal with the patient who evokes powerful feelings in the analyst. It describes how 'tolerating' such countertransference can, by itself, produce psychic change in the patient. This occurs through inevitable partial acting out

by the analyst, and the patient's observation of this. Implications of this interaction in the understanding of the mother-baby relationship are discussed.

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Translations of summary

Cet article examine le problème technique relatif à la manière d'aborder un patient qui suscite des sentiments puissants chez l'analyste. Il montre comment la 'tolérance' d'un tel contre-transfert peut elle-même amener un changement psychique chez le patient. Celui-ci se fait en partie et inévitablement par acting-out de la part de l'analyste, et l'observation que le patient en fait. L'auteur discute les implications de cette interaction pour la compréhension de la relation mère-bébé.

Dieser Aufsatz untersucht das technische Problem des wie mit einem Patienten umzugehen ist, der sehr starke Gefühle im Analytiker erzeugt. Es wird beschrieben wie das 'Tollerieren' einer solchen Gegenübertragung in sich selbst schon psychische Veränderung im Patienten bewirken kann. Dieses findet statt auf Grund von unvermeidbarem teilweisen Ausagieren durch den Analytiker und des Patienten Beobachtung dieses Vorganges. Es wird diskutiert welche Folgen sich aus dieser Wechselbeziehung für das Verständnis der Mutter-Kleinkindbeziehung ergeben.

El artículo explora el problema técnico de como manejarse con el paciente que evoca poderosos sentimientos en el analista. Describe cómo 'tolerar' una tal contra-transferencia puede en si mismo producir un cambio psiquico en el paciente. Esto ocurre por inevitables acting-outs parciales por parte del analista, y su observación por parte del paciente. Se discuten las implicaciones de esta interacción en la comprensión de la relación madre-bebé.

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