

Categories of Countertransference

Therapists are often affected by their patients' attempts to influence them. Furthermore, therapists are predisposed to influence patients in ways which reflect their own psychological difficulties rather than their therapeutic ideals. While countertransference has received increasingly more attention within psychoanalysis, the subject has received but scattered notice by writers outside the psychoanalytic schools. Since a great many psychotherapists now consider themselves eclectic (1, 2), the study of therapists' responses to psychotherapy should be adjusted for use in all forms of psychotherapy.

Freud introduced the term countertransference to describe the analyst's transference to the patient (a patient might come to represent a figure from the analyst's past) and also included any other problems which might be stimulated in the analyst by the patient's communications (3). He recognized that patients influence therapists' unconscious feelings (4) but took this idea no further than to suggest that countertransference reactions were resistances to therapy which should be overcome through self-examination and/or personal psychoanalysis. Freud did not take the step he had taken with transference which he at first regarded only as an impediment but later integrated into his treatment model. Instead, countertransference remained for him an impediment of little use to the therapeutic process (3).

Others have taken this next step, thereby triggering an ongoing debate within psychoanalytic circles about the value of the therapist's responses to the patient. The outlines of the debate are drawn by questions of categories. Is countertransference only the result of the therapist's psychological difficulties (the classical position)? Is countertransference also a response to the patient's attempt to influence the therapist (the interactional perspective)? Which therapists responses should not be included under countertransference? Once recognized, how should countertransference reactions be used? See Epstein and Feiner (5), Sandler (3), and Langs (6) for re-views of the Freudian psychoanalytic literature.

In this paper I take the following positions:

- I. In all forms of psychotherapy, therapists are inevitably influenced by their patients.
2. Therapists must overcome both their tendency to

think of themselves as unaffected by their patients and their reluctance to examine their own responses.

3. Therapists must come to recognize their own range of distorted and non-distorted feelings and fantasies in order to recognize when they should examine themselves for countertransference responses.
4. Countertransference responses must be differentiated from other classes of therapist responses including empathy, intuition, theoretical and practical knowledge, and therapeutic caring.
5. The manner in which therapists respond to the influence of their patients may be considered a distorted form of empathy, an understanding of which may be grasped after distinguishing the therapist's neurotic contribution.
6. The stages of the psychotherapeutic process predict types of countertransference reactions.
7. Once the therapist's contribution to a countertransference reaction is understood and separated from the patient's influence, the patient's contribution may be incorporated into any number of interventions depending upon the therapist's chosen technical predispositions.

Requirements for and Resistances to Therapist Self-Observation

In order for a therapist to place his/her attention upon countertransference responses during and after psychotherapy sessions, the therapist must (a) be convinced that the effort is valuable, and (b) be willing to acknowledge his/her own emotional vulnerability. To be convinced of its usefulness, therapists need to recognize that patients influence therapists both purposefully and inadvertently. Since much of the reason patients present for therapy is related to the manner in which they conduct their interpersonal relationships, these introspective data provide here-and-now understanding about other rela-

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tionships. At least one study has confirmed that therapists react to their patients as do significant others (7). In order to isolate the patient's contribution, therapists must first be willing to examine the contribution of their own psychological vulnerabilities. This process requires therapists to relinquish their omnipotent, perfectionistic therapist image and, as Sullivan (8) so often insisted, to accept their own humanity.

Signs of Countertransference

Any exaggerated, inappropriate feelings, behaviors, thoughts, and fantasies about patients may indicate countertransference distortions which probably deserve self-scrutiny. Menninger (9) has listed some common forms. Each is a signal to the therapist of distorted intrapsychic and/or interpersonal elements. Each therapist must learn to recognize his/her own individual range of noncountertransference based feelings, fantasies, and behaviors and to develop warning signals when these individual norms are exceeded. I believe there is considerable variation among therapists since some are more apt to recognize feelings, others to fantasize, and yet others to act. Individual sensitivity to these avenues of countertransference manifestation is also highly variable since therapists may dampen or augment their responses.

Therapist feelings which suggest distortions in either or both participants include: anxiety, guilt, anger, sexual stimulation, fear, disappointment, despair, shame, boredom, indifference, helplessness, envy, awe and excessive pride in the patient's accomplishments or praise.

Rather than experience these feelings, therapists may convert them into apparently appropriate therapeutic behaviors, rationalized by theoretical explanation. Any technique may be used in the service of avoidance of countertransference awareness. Excessive silence or excessive activity may act as countertransference resistances (counterresistances). Carelessness in the management of the contract (being late, running over time, raising or lowering the fee) may also be indicators. Unnecessary reassurances (possibly intended to keep the patient dependent), critical or seductive tones and posturing and other non-verbal or latent communications may also serve as counterresistances. Asking favors of the patient, and trying to impress the patient are clearer indications of therapist distortions. Bragging to other therapists about a patient's success, anxiously describing a patient's lack of progress or making fun of a patient's idiosyncracies each may indicate countertransference distortions. Displacing the patient's anxiety onto another may also indicate countertransference as illustrated by the following case:

Case 1: A 38-year-old paranoid man exhorted his therapist to believe that the world economic system was about to collapse and that blood would soon run in the

streets. The only solution was to buy gold, the commodity which best held its own value. After weeks of intense lectures, the therapist began to urge his wife to study finance.

A variety of therapist thoughts and fantasies may signal countertransference distortions. Fantasies of sexual union, of romance, of bearing children together, of being best friends, of being harmed by or hurting the patient are not uncommon therapist experiences. Obsessive fears of losing the patient either through premature termination or through suicide often indicate distortions. Making one's career dependent upon success or failure with a specific patient should elicit questions about "why now, with this person?" The greater the intensity of emotion accompanying these thoughts the greater the need to examine them.

Nocturnal or day dreaming often deserves attention when a patient is a central figure, as illustrated by the following case:

Case 2: A 28-year-old divorced woman who had made multiple suicide attempts and had poor ego boundaries, presented in a very helpless manner, wanting me to see her more often than she could afford or I had time. After the first session, I had the following dream: I am having sex without penetration with an adolescent girl. I want to put on a rubber but I don't want to penetrate. I will feel guilty about my wife if I do. There is noise of upset men talking. One rushes off to settle a contract dispute. I believe it is her father. She follows him. I am somewhat relieved but try to follow her. I wake up. My interpretation was: I am becoming intensely involved with her but we have not worked out a contract to our mutual satisfaction. We were both experiencing intense intimacy and the desire to run away from it. This dream predicted difficulties which will be described as part of another illustration.

Another potential indicator of countertransference may be tapped by careful monitoring of latent content messages. Discussion of physicians, teachers, certain friends, and parents may indicate patient opinions about the therapist which are either transference distortions or accurate unconscious descriptions of the therapist's countertransference (Langs (6), p. 567). For example, if a patient describes a leader as afraid to take control of the organization, the patient may be referring to the therapist's own failure to address troublesome issues.

The model offered by cognitive therapists (e.g. Ellis (11), Beck (12), Meichenbaum (13)) for approaching distorted cognitions is useful here. The dysphoric emotion, fantasy, or dream signals the need to search for cognitions which are not adaptive and therefore must be challenged through testing them as hypotheses about real-

ity rather than accepting them as absolute facts. Coupled with the psychodynamic notion that many of these thoughts, feelings, and fantasies may operate as part of a defensive response to other unwanted thoughts and/or feelings, therapists may be better equipped for self-examination in order to learn more about themselves and more about their patients. Reflection upon the feelings and thoughts, allowing them to run freely, may reveal their origins. Discussion with a trusted colleague may be required to elucidate understanding not readily available through self-scrutiny.

The willingness to examine oneself as a therapist brings with it potential guilt for any countertransference reaction. Therapists who believe that all of their distorted responses signal the need for further psychotherapy may become paranoid about such reactions and avoid them. On the other hand, therapists willing to look at themselves for information about their patients may neglect their own contributions, preferring to see the patient as the sole contributor. A yet more intricate complication occurs when therapists become guilty about a self-induced countertransference reaction and then unconsciously blame the patient. For example, a therapist may "forget" a session, feel very guilty about it, ignore the dysphoria by further forgetting about the patient, and by scheduling someone else for the next session time.

Therapist Responses Distinct From Countertransference

Countertransference does not include *all* therapist responses to psychotherapy. Among the non-countertransference therapist responses which are to be distinguished from countertransference are empathy, intuition, clinical and theoretical knowledge, technique, and therapeutic caring.

Empathy is an intrapsychic process by which the therapist partially and momentarily identifies with the patient in order to imagine what this person-patient might be experiencing. The data for this understanding come partly from wondering what the therapist might experience under the circumstances described by the patient; therefore, the process is largely conscious. Because patients influence therapists in ways which often circumvent conscious processes, therapists may come to comprehend the patient's experience without at first knowing it. By acknowledging the possibility of empathic comprehension through out-of-awareness channels, therapists may turn countertransference responses into helpful therapeutic data.

In extending the psychoanalytic view of empathy to the treatment of disorders of the self, Kohut (Wolf (14)) suggested that controlled self-object countertransference provided an important source of countertransference data. Because "there always remain unfulfilled longings to be

mirrored and unfulfilled strivings to merge into an idealized image" (14, p. 454), therapists will allow their patients to become self-objects for them. The manner in which the patient does this (e.g., by evoking feelings of omniscience and omnipotence) may provide data which, upon introspection, reveal the nature of the patient's self-representations.

In the treatment of the more disturbed borderline patients, Kernberg (15) described the dangers of empathic contact which may lead to countertransference reactions. In order to maintain emotional contact with disorganized patients, therapists are involved in a process of empathic regression which may reactivate their own more archaic states of mind. Kernberg cited several "dangers from within" as a result of the reactivation of more disorganized states of consciousness: (1) some loss of self-other boundaries with that patient; (2) a strong temptation to control the patient because he/she has become identified with a person in the therapist's past who represented danger; and (3) anxiety associated with these early fears and impulses associated with previous persons but now directed toward the patient. These issues were clearly brought home to me in the psychotherapy of the 28-year-old woman with multiple suicide attempts described in case 2.

Case 2 continued: I continued to have trouble sleeping because I thought of her often and felt quite anxious when I did. I had difficulty pushing her out of my mind. I worried about her suicide potential and became convinced that my actions predetermined her degree of risk, thereby reflecting a loss of self-other boundaries. I was reminded of anxious feelings for my mother accompanied by a sense that I could not do enough for her in order to make her happy. I made no adequate responses to the patient's interpretations of my behavior as deliberately malicious. As my feelings for both the patient and my mother began to fuse, I felt increasingly more helpless and agitated. I was afraid to follow the rules of the contract (time, place, fee, telephone calls) although I knew I should have. I was afraid to withhold from her during therapy as well. I attempted to control her by indirect expressions of anger and further attempts to pacify her. Finally when we seemed to reach some sense of compromise, she made a suicide gesture with medications other than the ones I had given her. During her subsequent hospitalization I met with her, her sister-in-law and brother. The sister-in-law expressed concerns almost identical with mine: she feared that without her proper behavior the patient would kill herself. She also felt trapped by these implicit threats and was no longer able to handle her own agitation and anger about the situation. The sister-in-

law's response confirmed that I was experiencing a patient-induced countertransference.

Intuition is a "still small voice" (16) or visual image which seems softly to claim correctness without immediately available evidence. It is a hunch which seems free of emotion and conflict but like signs of countertransference it must be tested for distortion as well. Knowledge serves the vital function of categorization, discrimination and prediction. However, theoretical knowledge and clinical experiences may masquerade as correct perception when such responses may be functioning in the service of neurotic countertransference.

Case 3: A therapist became anxious during her first session with a 28-year-old, dark-haired, depressed, obsessive man. She realized that he strongly resembled a patient of hers who after 15 sessions had committed suicide. She became afraid that this new patient would also commit suicide. Believing she was unable to help him, she negotiated a transfer. The next therapist was able to disconfirm her fears thus suggesting a neurotic countertransference reaction based partly upon a previous clinical experience.

Any technical maneuver may represent a manifestation of countertransference. Technical aberrations would be more easily defined if proper technique were known. The practice of psychotherapy is no certain endeavor and its techniques are quite optional. Long silence, self-revelation, the assignment of homework, and role-playing may each represent divergences from some acceptable set of techniques. This technical variation makes a priori judgement of technique which represents countertransference quite difficult to judge. The context of the therapist's style, the patient's needs and the stage of therapy must therefore be taken into account.

Finally, therapists often care about these people they call patients. Liking them may be correlated with positive outcome (17). We hope for the best; we are saddened by their failures, gladdened by their accomplishments; and we suffer real losses when they complete therapy. Any of these reactions may become exaggerated. When they do, then countertransference must be considered.

Therapist-Induced Countertransference

The two general classes of countertransference reactions are distinguished by their sources: therapist-induced and patient-induced. However, no countertransference reaction is either one or the other type since therapists are susceptible to their own personal vulnerabilities as they are triggered by each patient. The two general classes of countertransference reactions can only be differentiated by degrees.

Personal factors which influence the development of

therapist-induced responses include evocation of significant past figures, defensive denial, professional events, and current life events.

Evocation of significant past figures. In a variety of ways, patients may evoke response patterns connected to earlier significant others including earlier self-identities, siblings, aunts, uncles, and cousins as well as parents. The following example illustrates a classical oedipal evocation:

Case 4: A 30-year-old female therapist was seeing a 60-year-old depressed man who had prostate cancer. She had difficulty with his statements about liking younger women and was confused by his mild but persistent sexual advances toward her. She was afraid to confront him on his sexual interest in her, fearing that he would leave her. On the other hand, she knew she needed to confront him in order to keep therapy moving. She became paralyzed by these contradictory injunctions until the patient slipped away from therapy never to return. In discussing this case with a colleague, she realized that although she knew that this man in some way resembled her deceased father who was seductive toward her and had died of prostate cancer, she had not realized how much the similarity had paralyzed her. Among the possible interpretations were her wish for sexual contact coupled with her fear of its association to his death.

Defensive denial. Not only may figures from the past be evoked and denied but patients may also trigger therapist awareness of feelings and thoughts which are not directly tied to the past but which do create discomfort when considered. These content areas form therapist "blind spots," sectors of thought and feeling which are guarded from intrusion. For example, therapists commonly do not like to experience patient rage directed at them and may avoid discussion of anger. Or they may enjoy patients' adoring affection and neglect the aggression underlying the affection. Therapists who drink excessively may avoid addressing the alcoholism of some of their patients. Together therapist and patient may collude to avoid discussing the content sensitive to both of them.

Case 5: A 28-year-old woman therapist was treating a 16-year-old woman who entered therapy because she believed she was about ready to declare herself a lesbian. After 10 sessions, the therapist was startled when the patient wanted to terminate treatment. Her reason was, "I am in love with you." The therapist reproached herself because she had failed to address the latent clues of this patient's growing sexualized affection for her. Her blindness reflected her own unwillingness to understand her sexualized affection for some other women.

Professional events. Many of the choices and events associated with professional activities have countertransference implications because they influence therapist conduct with specific patients as well as their general practice. What personality factors influence the choice of therapeutic school? Why are some attracted to short-term hypnotic manipulation and others to long-term delicate psychoanalytic involvement? Certainly factors such as geographical location, profession, and training institutions have some bearing, but what are the personal factors which influence these decisions? Could it be that therapists who want long-term intense relationships are searching for lost loves and intimacy? Could it be that those who are afraid of long-term contacts choose active manipulation for the short term? These questions deserve closer investigation.

Therapists are strongly influenced by the context of their practices. Therapists in training must often experience many forced terminations; some come to dislike their patients because they represent obligations imposed upon them by their training programs. Therapists in institutions may be forced to see more patients than they wish and react negatively to additional referrals. Therapists in solo practice may find the isolation painful, creating ambivalence about what type of patient and how many to see. When a Very Important Person is referred for treatment, therapists may feel that the whole world is watching and become overly self-conscious about their efforts. Presentation of cases to supervisors may also have strong negative influences.

Case 6: In the early part of his career, the author of many books on psychotherapy conducted a workshop in psychotherapy during which I presented a case in front of an audience of 200 psychiatrists. My style had only moderate overlap with his. He was intensely critical and I was devastated. In retrospect, the patient I presented became associated in my mind with great power to hurt me thus causing me to avoid confronting her in a number of critical areas. Furthermore, as therapy became increasingly more stalemated, I became ambivalent about seeking further supervision only partly aware that I feared being devastated again.

Current life stages and events. Like their patients, therapists' lives also traverse the common cultural and biological events which often have tremendous impact on personal and professional relationships. The birth of a child, for example, may increase understanding of infantile states in patients while decreasing the levels of nurturance and commitment. Divorce may increase desire for involvement with some patients with an accompanying loss of objectivity. A major illness may increase guilt for deserting patients as may the grieving for a lost loved one. Patients notice these changes (wedding rings, maturity,

withdrawal) and although they may not comment directly, many react to these changes as well.

Case 7: A therapist assumed that his psychotic patient needed information about his grieving for a loved one because of her shaky reality testing. He believed she must have noticed his changed demeanor. Therefore he told her some details. The patient experienced the therapist's revelation as an overwhelming demand that she care for him, an experience which recapitulated her major childhood relationships. This revelation derailed therapy and led to a premature termination. He later realized that he needed to be cared for and also wanted to deflect her rage at his emotional unavailability (18).

In addition to inducing avoidance and paralysis, psychological problems may also result in therapist attempts to manipulate patients into playing roles which fit the therapist's personal needs. Most obvious is the seduction of patients for sexual purposes. More conventionally used techniques may also be incorporated in the service of therapist interpersonal and intrapsychic conflicts.

Case 8: A 32-year-old therapist with fantasies of tying women with ropes and having them helpless and willing to follow instructions was treating a 25-year-old woman who stimulated him sexually. She reported that she felt very helpless and bound in her marriage. The therapist decided to use "psychodrama" and suggested that she act like a "bound and helpless" housewife. The therapist instructed the patient to put her hands behind her back, pretend that her mouth was gagged and struggle to get free.

Patient-Induced Countertransference

Patients also attempt to wrest responses from therapists which fit their conscious and unconscious needs. Because these efforts are often subtle, outside of awareness, and strike sensitive personal notes in therapists, their sources may be difficult for therapists to pinpoint. At first introspective glance, therapists may notice symptoms of personal conflict to which they tend to respond by either ignoring them or by becoming obsessively concerned with the search for their origins within their own psyches. A third alternative is to hypothesize that the patient is evoking these responses by triggering aspects of the therapist's own intrapsychic symbolic-emotional network which correspond to elements in the patient's symbolic-emotional network. Consider the following example:

Case 9: A patient tormented by feelings of guilt and depression related, in part, to a longing for an uncle who had served as a father surrogate during his youth said: "Last night I had the following dream. I saw myself in a house with some cousin of mine in the

country. It was not yet dark, but it was no longer light, and I seemed to be all alone in the house. My cousin was elsewhere; I could not see him. I called out 'Peter' and somebody, in a joking way, called back 'Joey.' "

The therapist heard no more than this when he suddenly found himself having a vivid visual fantasy of standing at an airport terminal where passengers disembark from a distance. Among the passengers he recognized his father who had died a few years before. On thinking about this fantasy he recalled a sentimental journey he had made to the place of his father's youth, and it suddenly came to him that he felt in a twilight zone between life and death, an in-between land where it was possible for the living and the dead to be united.

Then the therapist imagined his patient might also be feeling (italic is mine) in a twilight zone, and recalled the names Peter and Joey were actually names the patient and his uncle had called each other. As the therapist began to emerge from his fantasy, he heard the patient speaking, "Last night I was watching television. The show was the 'Twilight Zone' ..." and it was not difficult for him to recognize the dream in terms of his patient's wish to be reunited with his uncle. Subsequent associations confirmed this recognition and made it possible for the therapist to transform it into understanding (from Beres and Arlow, quoted by Bachrach (19)).

Because the therapist believed that his fantasy about his father did not reflect a personal neurosis interfering with therapy but rather considered its appearance at that time to indicate something about the patient, he was able to translate the fantasy into empathic understanding. This hypothesis is at once both comforting and challenging. It is comforting because each therapist need not become "paranoid" by exaggerated or inappropriate responses to patients. It is challenging because therapists must examine each countertransference reaction very carefully in order to pick away the confounding influences of his/her own difficulties. No patient-induced response falls on a therapist's psyche pure of psychological conflict. The important question is not whether or not the therapist has contributed, but how much.

Patient-induced responses can be separated into two subcategories which may be difficult to distinguish upon close examination. The oddly responding therapist may be experiencing a personal derivative of the patient's internal state (concordant countertransference) or may feel impelled to assume a role which corresponds with the patient's interpersonal intentions (complementary countertransference) (20, 21). In object relations terms, the therapist may experience either the patient's self-representation or the manner in which the self attempts to form and maintain relations with others. For those pa-

tients whose self-other representations are fused, the distinction between concordant and complementary countertransference may become blurred. The therapist who registered a fantasy about his dead father in response to a patient's dream report experienced a concordant countertransference (*Case 9*). My anxious responses to a 28-year-old multiple suicide attempter (*Case 2*) represented a mixed complementary and concordant countertransference with a borderline patient. The therapist who instructed the 25-year-old woman to act like a "bound and helpless" housewife was not only fitting the patient into the therapist's fantasies but was clearly playing the dominant complementary role of her husband (*Case 8*).

The mechanisms by which these responses are triggered in therapists deserve clarification. The Kleinian term "projective identification" is in part defined as attempts by the patient to "place the contents of his/her mind into the mind of the therapist." This phrase implies a blank screen of the therapist's mind or, more three-dimensionally, an empty container. Instead, it would be more accurate to suggest that patients evoke these responses from a mind full of thoughts and emotions through a variety of subtle stimuli which deserve further study and discrimination.

The Influence of Stages of Psychotherapy on Countertransference

Because the psychotherapeutic relationship is a series of events through time it may be called a process. This process may be divided into stages which are consistent across a variety of different forms of therapy (22). The stages may be defined by their objectives: engagement, pattern search, change and termination. Therapist reactions to patients (as well as patient reactions to therapists) are partly determined by the stage in which they are working.

During the engagement stage therapists react to the surface presentations of their patients. Following is a list of surface triggers and some probably not uncommon therapist self-statements which deserve further self-scrutiny:

1. Age: Older people cannot be helped psychotherapeutically; I won't try (23).
2. Sex: This man is a typical chauvinist. I do not want to help him.
3. Dress and manner: She dresses so expensively and is so gracious. I wonder if she can accept my help.
4. Physical attractiveness: She is just the kind of woman I'd like to marry. I'd like to stop therapy before it starts and ask her for dinner.
5. Socioeconomic class: I don't want a blue-collar clientele. No reason to start now.
6. Race: I never want to be alone in a small room with a black male (24).

7. Sexual orientation: Homosexuality is wrong. I cannot accept this in a patient.

These self-statements represent biases present in our culture. Since therapists are part of the culture, they are influenced by them.

Patients may induce responses in their therapists during the initial meeting which can help in making their diagnosis as suggested by my dream in *Case 2*. Borderline and narcissistic patients, particularly, may rapidly induce reactions typical of their self-other representations (15).

During the pattern search, therapists seek to define cognitive-emotional-behavioral patterns which, if changed, would benefit the patient. Therapists may react to the content of the investigation as well as to the often increasing affection and dependence of their patients. Because patients often attempt to apply those interpersonal maneuvers used in relationships with previous important others (e.g., guilt, seduction, helplessness) (25), therapists may find themselves responding in ways which resemble the reactions of other people in the patient's life. Because trust has been reasonably established, patients are more likely to communicate directly and indirectly their internal states which may be picked up through unconscious means and enter the therapist's awareness through a countertransference signal. Patients who are unable to define patterns to be changed may evoke frustration in therapists searching for such patterns. The patient's difficulty in accomplishing the objectives of the pattern search may be examined as reflection of a problem pattern. Patient problems may strike too close.

Case 10: A 27-year-old therapist was treating a 27-year-old man who wanted to establish intimate relationships with women but could not figure out what he was doing wrong. Something always happened to get in his way. Try as he might to find ways of acting and talking to meet them and keep them he could not find the right answers to achieve his goal of good sex and closeness. The therapist found himself quite frustrated with this man, did not know how to help him and tended to retreat to a caricature of psychoanalytic methods hoping to find the set of events in his past which caused him to be this way. In supervision, he was able to recognize that his client's pattern of attempting to plan how to "get girls" through correct word and action was strikingly similar to the therapist's collegiate approach to the same problem which was only slightly more effective. Having realized this similarity, he was able to more clearly separate himself from his client and to be more objective about their differences.

During the process of change, therapists apply specific techniques designed to help them to change their mala-

daptive patterns. Any technique may be used inappropriately, angrily, or vindictively in the service of countertransference. The silence of psychodynamic therapies may be used to punish patients through therapist withdrawal. Interpretation may harbor indirect criticisms. Attempts to correct cognitions may be couched in derogatory and demeaning terms through which clients are ridiculed for their misconceptions. Behavioral suggestions may be poorly selected to reinforce a sense of failure by having low probabilities of success. The process of change itself may evoke anger at its often back and forth progress. Therapists and patients may become stalemated because their respective styles fit so neatly together. For example, should a perfectionistic therapist be treating a patient who is afraid to separate, therapy can last indefinitely since the therapist will continue to find problems and the patient will avoid termination. Or should a highly intellectualized therapist be matched with a patient who avoids experiencing feeling, the therapist may find pleasure in the patient's ideas and permit him/her to avoid feelings. Finally, if a nurturing, supportive therapist who is afraid of causing frustration and anger is paired with an unassertive, dependent person, then the therapist may remain supportive and the patient may not change. If the dependent patient does begin to change, the nurturing therapist may find the patient less appreciative of support, thereby bewildering the therapist because the roles are shifting. Therapists may feel guilty for participating in the breaking of a marriage and, on the other hand, may take too much responsibility for patient success.

Termination represents separation and loss for both participants. Patients who are attractive, interesting, clearly appreciate the therapist and pay their bills on time may be hard to lose. Patients who desperately long to remain in therapy may evoke ambivalent responses to termination in the therapist.

Case 11: A 26-year-old woman had traversed the psychological continuum from borderline to narcissistic to neurotic character with her 35-year-old therapist over a period of 6 years. Soon after they had started therapy she had voiced her wish to simply lie in bed with him and be held. As termination neared, her sexual longing reappeared but she refused to discuss it directly. Instead she precipitously got married to a farmer without discussing it with her therapist. After she told him, the therapist had a dream in which she placed a shaft of wheat into his penis, a painful experience. She had "given him the shaft." They terminated shortly thereafter because he felt he could no longer help her. She was referred to another therapist with whom she was able to discuss her intense anger at the previous therapist for not capitulating to her sexual wishes, thereby completing the termination process.

Uses of Countertransference

By accepting the possibility that patients evoke distorted responses from them, psychotherapists enter an exciting new area of personal and professional discovery. Not only does countertransference awareness impel therapists to examine the personal influences of past and present which are contributing to the distortions but also encourages them to understand the nature and manner of the patient's interpersonal influence. By attempting to tease out the strands of interpersonal causes from personal ones each therapist is performing a necessary exercise of individuation — the differentiation of self from other. Since therapist personality is so much a part of the psychotherapeutic instrument, these intrapsychic and interpersonal refinements offer the possibility of increasing therapist effectiveness as well as aiding personal growth.

If therapists accept that patients are often aware of countertransference reactions, then they may allow themselves to acknowledge their patient's accurate perception. Such acknowledgement does not necessarily require elaboration of the origins as offered by the grieving therapist in *Case 7*, much to the detriment of therapy. Rather, acknowledgement may validate the patient's ability to perceive reality and, like any crucial event in therapy, may then become the subject for discussion: how does this therapist response affect the patient? Without acknowledgement of countertransference, therapists may suggest that the patient is perceiving the therapist according to a transference distortion, thereby continuing a process of disconfirming the patient's ability to comprehend others accurately.

When the therapist's personal contribution to a countertransference reaction is reasonably well separated from the patient's contribution, the remaining information is simply another form of knowledge about the patient. Like data collected from direct patient description, latent content implications, family members, or homework assignments, patient-induced countertransference information must be confirmed by other data and then formulated into interventions. Therefore, the manner in which patient-induced countertransference information is to be used depends upon each therapist's preferred psychotherapeutic techniques.

Case 12: A 23-year-old homosexual man with multiple, shifting physical pains with no discernible organic etiology was referred to a male psychiatrist to be followed concurrently with his primary care physician. The patient appeared erratically at their weekly sessions, usually promising to appear the following week, often skipping for months. Confrontations were ineffective. After 12 months, during a crisis in which he may have inadvertently given a friend herpes through an unplanned sexual encounter, he hysterically called

the psychiatrist. The therapist helped to ease the patient through the emergency and that night had a dream in which his 14-month-old son turned into a rat who scurried around the house. He awoke with a start and immediately associated to the patient whose attendance at meetings was inadvertently harmful in a way vaguely reminiscent of the manner in which he had exposed his friend to herpes. The therapist decided to bring the issue of regular appointments to the next meeting. The patient began that meeting talking about how he needed to lay down some rules for another friend who was taking advantage of him. The therapist silently interpreted this latent content as confirming the need for an intervention about regular appointments. The patient was at first defensive about the confrontation. However, he discovered how difficult it was for him to say directly that he needed the therapist's help, fearing that he would be abused once again by another in a long series of men beginning with two foster fathers who had physically beaten him many times.

Perhaps the most controversial use of patient-induced countertransference knowledge within psychoanalysis is to express the information directly to the patient. Tauber (26) for example, suggested telling patients dreams, feelings, and thoughts in which they appeared while Weigert (27) suggested that such responses be expressed only during termination. Langs, on the other hand, stated "such maneuvers are implicitly something of a hoax, a seduction, and a conflicted imposition of the analyst's problems onto the patient" (6, Vol. 2, p. 288).

Outside of psychoanalysis, Rogers (28) advocated genuineness in addition to warm, empathic regard, and non-judgemental acceptance. By genuineness he meant direct expression to the client about how the therapist was reacting to him/her. Such reactions can provide useful feedback about how others may also respond to the client. This behavior may also serve as a model for the patient's own self-expression. Among the chief advocates of direct self-expression are existential therapists who tend to believe that direct emotional encounters between patient and therapist is healing (29). Yalom (30, p. 402-403) listed a series of anecdotes which demonstrated that therapists believed that their patients changed because the therapists were willing to encounter them in a real and human way. Weiner (31) has compiled a number of different circumstances under which therapists may safely and effectively disclose their responses to patients. This controversy seems to indicate that therapist self-revelation may function as yet another psychotherapeutic technique, the use of which must be judged relative to the therapist's personality, the patient's needs, and the stage of psychotherapy.

Future Directions

To accept countertransference reactions as not only

inevitable but also useful, is to continue the movement toward acknowledging the importance of the therapist's own personality along with technique and theory. Further study of the therapist's self in therapy could uncover means to accelerate the data gathering and change process. For example, it may be possible to judge the style of therapy most appropriate to specific patients by noting the countertransference reaction which the patient induces. Emotionally deprived patients who evoke marked confusion in the therapist may best be served by rigidly firm management of the therapeutic contract and a distant and reserved therapist. On the other hand, patients who evoke collaborative countertransference tendencies may best be served by an experimentalist approach.

Many problems are to be solved should therapists continue the study of their reactions to psychotherapy. How, for example, are patient-induced responses to be separated from therapist-induced responses? Can any guide-lines be developed? One such guideline in regard to therapist fantasies might be the following: if the therapist's countertransference fantasy or dream is composed of elements which closely resemble those of familiar fantasies, then the response is likely to be more the therapist's doing than the patient's. If the fantasy material is somehow strikingly new or perhaps from years past, then the response is more heavily influenced by the patient.

These and many other questions await the study of the person-who-is-the-instrument of therapeutic change.

References

- Garfield SL, Kurtz R: Clinical psychologists in the 1970's. *Am Psychologist* 31:1-9, 1976
- Marmot J, Scheidemandel PL, Kanno CK: *Psychiatrists and Their Patients*. Washington, D.C., American Psychiatric Association, 1975
- Sandler J, Holder A, Dare C: Basic psychoanalytic concepts: 1V. Countertransference. *British J Psychiatry* 117:83-88, 1970
- Freud S: The future **prospects** of **psychoanalytic psychotherapy** (1910) in Freud, *Therapy and Technique*. Edited by P Rieff, New York, Collier, 1963
- Epstein L, Feiner A: Introduction. In *Countertransference*. Edited by L Epstein, A Feiner. New York, Jason Aronson, 1979
- Langs R: *The Therapeutic Interaction*. New York, Jason Aronson, 1976
- Mueller W: Patterns of behavior and their reciprocal impact in the family and in **psychotherapy**. *J Counseling Psychology* 16 (2, Part 2)
- Sullivan HS: *The Psychiatric Interview*. New York, Norton, 1953
- Menninger K: *Theory of Psychoanalytic Technique*. New York, Harper and Row, 1958
- Langs R: **Psychotherapy: A Basic Text**. New York, Jason Aronson, 1982
- Ellis A: *Rational-Emotive Therapy in Current Psychotherapies*: Edited by RF Corsini, Itasca, Illinois, F. E. Peacock, 1973
- Beck A, Rush J, Shaw B, Emery G: *Cognitive Therapy of Depression*. New York, Guilford, 1979
- Meichenbaum D, Gilmore J: Resistance from a Cognitive-Behavioral Perspective in *Resistance*. Edited by P Wachtel, New York, Plenum, 1982
- Wolf ES: **Countertransference** in Disorders of the Self. In *Counter-transference*. Edited by L Epstein, AH Feiner, New York, Jason Aronson, 1979
- Kernberg O: *Borderline Conditions and Pathological Narcissism*. New York, Jason Aronson, 1975
- Weil A: *The Natural Mind*. Boston, Houghton-Mifflin, 1972
- Gomes-Schwartz B, Hadley SW, Strupp HH: **Individual psychotherapy and behavior therapy**. *Annual Review Psychology* 29:437-471, 1978
- Givelber F, Simon B: A death in the life of a therapist and its impact on the therapy. *Psychiatry* 44:141-149, 1983
- Bachrach HM: Empathy. *Arch Gen Psychiatry* 33:35-38, 1976
- Racker H: *Transference and Countertransference*. New York, International Universities Press, 1968
- Lakovics M: Classification of countertransference for utilization in **supervision**. *Am J Psychotherapy* 37:245-257, 1983
- Beitman BD: Comparing **psychotherapies** by the stages of the process. *J Operational Psychiatry* 14:20-28, 1983
- Lewis JM, Johansen KH: Resistances to **psychotherapy** with the elderly. *Am J Psychotherapy*, 36:497-504
- Griffith MS: The influences of race on the psychotherapeutic relationship. *Psychiatry* 40:27-40, 1977
- Cashdan S: *Interactional Psychotherapy*. New York, Grove and Stratton, 1973
- Tauber E: Exploring the therapeutic use of countertransference data. *Psychiatry* 17:331-336, 1954
- Weigert E: Countertransference and self-analysis of the **psychoanalyst**. *Intl J Psychoanal* 35:242-246, 1954
- Meador B, Rogers C: Client-Centered Psychotherapy. In *Current Psychotherapies*. Edited by R Corsini, Itasca, Illinois, FE Peacock, 1973
- Havens L: Existential use of the self. *Am J Psychiatry* 131:1-10, 1975
- Yalom I: *Existential Psychotherapy*. New York, Basic Books, 1980
- Weiner MF: *Therapist Disclosure*. Baltimore, University Park Press, 1983

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- Garfield SL, Kurtz R: Clinical psychologists in the 1970's. *Am Psychologist* 31:1-9, 1976
- Marmor J, Scheideman PL, Kanno CK: *Psychiatrists and Their Patients*. Washington, D.C., American Psychiatric Association, 1975
- Sandler J, Holder A, Dare C: Basic psychoanalytic concepts: IV. Countertransference. *British J Psychiatry* 117:83-88, 1970
- Freud S: The future prospects of psychoanalytic psychotherapy (1910) in Freud, *Therapy and Technique*. Edited by P Rieff, New York, Collier, 1963
- Epstein L, Feiner A: Introduction. In *Countertransference*. Edited by L Epstein, A Feiner, New York, Jason Aronson, 1979
- Langs R: *The Therapeutic Interaction*. New York, Jason Aronson, 1976
- Mueller W: Patterns of behavior and their reciprocal impact in the family and in **psychotherapy**. *J Counseling Psychology* 16 (2, Part 2)
- Sullivan HS: *The Psychiatric Interview*. New York, Norton, 1953
- Menninger K: *Theory of Psychoanalytic Technique*. New York, Harper and Row, 1958
- Langs R: *Psychotherapy: A Basic Text*. New York, Jason Aronson, 1982
- Ellis A: *Rational-Emotive Therapy in Current Psychotherapies*: Edited by RF Corsini, Itasca, Illinois, F. E. Peacock, 1973
- Beck A, Rush J, Shaw B, Emery G: *Cognitive Therapy of Depression*. New York, Guilford, 1979
- Meichenbaum D, Gilmore J: Resistance from a Cognitive-Behavioral Perspective in *Resistance*. Edited by P Wachtel, New York, Plenum, 1982
- Wolf ES: Countertransference in Disorders of the Self. In *Countertransference*. Edited by L Epstein, AH Feiner, New York, Jason Aronson, 1979
- Kernberg O: *Borderline Conditions and Pathological Narcissism*. New York, Jason Aronson, 1975
- Weil A: *The Natural Mind*. Boston, Houghton-Mifflin, 1972
- Gomes-Schwartz B, Hadley SW, Strupp HH: Individual **psychotherapy** and behavior therapy. *Annual Review Psychology* 29:437-471, 1978
- Givelber F, Simon B: A death in the life of a therapist and its impact on the **therapy**. *Psychiatry* 44:141-149, 1983
- Bachrach HM: Empathy. *Arch Gen Psychiatry* 33:35-38, 1976
- Racker H: *Transference and Countertransference*. New York, International Universities Press, 1968
- Lakovics M: Classification of countertransference for utilization in supervision. *Am J Psychotherapy* 37:245-257, 1983
- Beitman BD: Comparing psychotherapies by the stages of the process. *J Operational Psychiatry* 14:20-28, 1983
- Lewis JM, Johansen KH: Resistances to psychotherapy with the elderly. *Am J Psychotherapy*, 36:497-504
- Griffith MS: The influences of race on the psychotherapeutic relationship. *Psychiatry* 40:27-40, 1977
- Cashdan S: *Interactional Psychotherapy*. New York, Grove and Stratton, 1973
- Tauber E: Exploring the therapeutic use of countertransference data. *Psychiatry* 17:331-336, 1954
- Weigert E: Countertransference and self-analysis of the psychoanalyst. *Intl J Psychoanal* 35:242-246, 1954
- Meador B, Rogers C: Client-Centered Psychotherapy. In *Current Psychotherapies*. Edited by R Corsini, Itasca, Illinois, FE Peacock, 1973
- Havens L: Existential use of the self. *Am J Psychiatry* 131:1-10, 1975
- Yalom I: *Existential Psychotherapy*. New York, Basic Books, 1980
- Weiner MF: *Therapist Disclosure*. Baltimore, University Park Press, 1983