Countertransference in psychoanalytic clinical management

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1 INTRODUCTION

No analyst goes further than his own complexes and internal resistances allow (Freud, 1910 p.150)

In studying psychoanalytic theory, one comes into contact with a range of theoretical concepts which, when articulated with clinical practice, provides an opportunity for a more complete and deeper understanding. This is what happens with the concept of transference and countertransference, fundamental to psychoanalytic clinical practice and management in the setting.

The theme of this paper is countertransference and its implications for psychoanalytic clinical management. In order to understand the theme it is necessary to elucidate concepts which are directly related to the countertransference phenomenon. As can be observed through the conceptualization of counter transference presented by various authors.

Freud (1910, p. 150), says that the "'countertransference', arises as a result of the patient's influence on the unconscious feelings of the analyst and inclines to insist that he will recognize the countertransference, in himself, and overcome it". Freud (1912), further states that these emotional reactions are considered obstacles to the analytic treatment and as such must be recognized, that is, differentiated from the patient's emotions and finally dominated.

Grinberg (1963 *apud* ZIMERMAN, 2004) says that the countertransferencial phenomenon results from projective identifications originating from the analisand, which provoke in the analyst a state of projective counter identification. He says that this phenomenon generates emotional responses in the analyst. Almeida (2010) speaks of the importance of the phenomenon in the analytic process, as well as the manner in which the analyst prepares himself for its "handling".

Zimerman (2004) understands that the counter transference generates emotional replies and warns on the importance of the analyst evaluating them, in order to differentiate what is his own transference and what is in fact counter transference. This is important, because the analyst must not

lose himself in identifying what is his and what is the patient's. The author refers to a triple aspect of the counter transference as an obstacle, as a technical instrument and as a field in which the patient can relive the strong emotional experiences he originally had.

It can be observed through the concepts presented above that the counter transference is a complex phenomenon, which needs many concepts to be explained, and for this reason the present work has tried in a simple and didactic way to clarify it, in order to be able to answer the guiding question "in what way is the counter transference implied in the analytic clinical management in order to answer in which situation it can contribute to the evolution of the adequate clinical process and in which it is placed as an obstacle?

The present work has as its general objective, to understand the various facets of countertransference in the analytical context. And as specific objectives, to explore psychoanalytic theoretical concepts in order to elucidate the concept of countertransference in an analytic clinical context; to demonstrate, from clippings of the reports of clinical psychology trainees, how the countertransference presents itself and what implications it brings to clinical management and to produce a didactic work that may contribute to the clinical training of psychology students.

The construction of this work is justified by the relevance of the theme and the need to understand the phenomenon in order to identify it and manage it adequately, making it useful to the therapeutic process and "eliminating" the obstacle aspect.

The interest arose from the first appointments of the group of trainees at the Applied Psychology Service (SPA), at Estácio de Sá College of Goiás, and from the supervision meetings of clinical cases. At that moment, the phenomenon was present and with it the problem, generating anguish and anxiety in the trainees. This occurred due to the students' lack of understanding about the various emotions presented during the first sessions. The intention of this work is to provide greater understanding of the phenomenon of counter-transference, so that this may help them in the identification and adequate management of counter-transference during the consultations.

The countertransference is defined as a relational phenomenon of the analytic clinic, since it arises "as a result of the patient's influence", therefore it is closely linked to the transference, central aspect of the analytic method. Its definition encompasses the unconscious emotional reactions of the analyst facing the affective onslaughts of the patient (ZAMBELLI, 2013).

Currently, transference is as important in the analytic setting as free association itself. For many it becomes one of the main key points for the treatment, so that the interpretation of its modalities allows the individual to know himself and to change. Thus, one can say that the patient finds himself in a privileged situation of revelation and observation of psychic phenomena, where he experiences the remembrance and repetition of the phenomenon. In a general sense, the transference frames all the phenomena that may exist in the relationship between patient and therapist (NASCIMENTO *et al.*,

2011).

Freud used various methods in the therapeutic relationship when investigating neuroses in general and, in particular, hysteria. In 1912 he states in "The Dynamics of Transference", that without the analysis of transference there is no psychoanalytic treatment. In this work Freud describes transference as a predominantly erotic and infantile phenomenon, he describes the origin and nature of transference through what happens in the subject's love life and through the combination of his disposition to love and the influences suffered during the first years of life.

In 1914, Freud attributes to the nature of transference three axes: reality/fantasy, conscious/inconscious and past/present, and that is why the repressed affective life is revived through this phenomenon. The revival of the recalcitrant and the importance of some unknown quality in the figure of the analyst were thus in the service of catharsis (Greek word for the process of purging or elimination of passions), since the impulse, once made conscious and explained to the patient, would be eliminated.

Transference was seen as a piece of associative mechanics in the "dialectics of the present and the past in the context of repetition and resistance" (ETCHEGOYEN, 1985 apud SOUZA, 2008). The specificity of this resistance is due to the psychic movement of the patient to transfer to the figure of the analyst, unconscious affections originally linked to the figure of another important person of his past. Freud calls this resistance "false attachment" (FREUD, 1895/2006, p. 313). The counter transference has become more present in psychoanalytic theory and has come, like transference, to play a fundamental role in clinical conduct.

Basically, the counter transference is the set of ideas, thoughts, feelings and impressions that are aroused in the analyst by the transference of the patient. To affirm that the analyst is not affected by the experiences of his patient is somewhat hasty and false. It would be the same as saying that the experiences of the patient, his pain and his behavior, are not seen by the analyst from the affective point of view. In this matter, it is up to the analyst to know how to open up to these experiences, work on them and treat them as useful and important information, not letting his experiences somehow get mixed up with those of his patient (HEIMANN, 1950 *apud* ZAMBELLI, 2013).

Although the concept of countertransference was little addressed by Freud in his works, it is possible to elucidate a moment in which the concept is cited. McGuire(1976 *apud* ZAMBELLI, 2013) cites an excerpt from a letter by Freud to one of his disciples Carl G. Jung, after receiving a communication from Sabina Spielrein - Jung's patient - who requested a meeting to discuss her love relationship with her analyst, where he says:

> [...] though painful, such experiences are necessary and difficult to avoid. It is impossible that, without them, we really know life and the things we deal with. [...] They help us to develop the shell, from which we need to master the countertransference which is after all a permanent problem (FREUD, 1909, cited by MCGUIRE, 1976, apud ZAMBELLI, 2013 p.183).

Through this excerpt, it is possible to perceive the importance of experiencing certain feelings in relation to the patient, because from such experiences the analyst will be able to understand life and the things with which they deal. Through "countertransferential feelings, it is possible to have better knowledge about the conscious and unconscious psychic processes that permeate the transference" (ZAMBELLI et al. 2013 p. 183).

Thus, it is possible to affirm that the connotation of unconscious resistance of the analyst comes from his own childhood complexes (BERNARDI, 2006 *apud* ZAMBELLI, 2013). Therefore, it is fundamental that such feelings be dominated and worked on, so that they do not become an obstacle in the analytic process.

For Freud (1912) the counter transference was an impediment in the analytical process. However, other authors such as Zimerman (2004) believe that if the analyst manages to perceive the effects provoked by the counter transference, one can make use of it in the therapeutic process provided one can differentiate the counter transference from the "analyst's transference".

It is worth remembering here that the analyst also has his own "contents", and that these may also provoke emotional responses, and that he should be capable of identifying what is his, so that there may be a differentiation of a genuine countertransference and a transference of the analyst towards the analisand (ZIMERMAN, 2004).

It is common to hear that analyst and analisand have fallen in love, although this is not impossible, the most probable is that there has been a transference of affect from primary objects of desire of the analisand to the person of the analyst and that the analyst, on the other hand, has felt this transference and "countertransferred" this affect (ZIMERMAN, 2004). Zimerman (2004) says that what differs the counter transference of the analyst to the transference of the same is the fact that in the counter transference, the analyst replies to this affective transference which the analisand is depositing on him, but he knows how to recognize that this affection deposited in him is something of the analisand and not of him. In the transference he allows his contents to mingle with the contents of the analyzing one, placing in the figure of the analyzing one his own contents.

To understand countertransference, it is necessary to understand projective identification, because as already mentioned, countertransference results from this concept. According to Melanie Klein (KLEIN, 1946 *apud* SEGAL, 1975), the ego, when exposed to the impact of anxiety-producing external reality, makes a projection and a conversion of the death instinct into aggressiveness, the ego divides itself and projects the part which contains the death instinct towards the external object. Just as the death instinct is projected in order to avoid anxiety, the libido is projected in order to create an

ideal object of satisfaction and life preservation. "Thus quite early on, the ego has a relation to two objects; the primary object the breast, is, at this stage, *split* into two parts, the ideal breast and the persecutory breast" (SEGAL, 1975 p. 37). In this way the ego's objective is to try to keep itself inside and identify with the ideal object and in return keep the persecutory object outside, that is, the part of the self that contains the death instinct. In this attempt the ego develops defense mechanisms, the defensive use of introjection and projection. Introjection means "the manner in which a subject fancifully introduces objects of external character into the internal." Projection "is the mechanism by which the subject projects onto another subject or onto an object desires which come from him, but whose origin he does not know, attributing them to an alterity which is external to him" (ROUDINESCO, 1944). From the original projection, another defense mechanism is developed: the projective identification. This projective identification can be directed either to the ideal object, to maintain it, or to the persecutory object, to control it.

In psychoanalytic clinics, patients present their needs, desires, demands, anguishes and defenses, and these constitute a "content" that needs to be welcomed by a "continent". Based on the understanding of projective identification, one can say that the patient projects onto the analyst his libidinal contents as well as his contents arising from the death drive. This defense mechanism is constituted in function of the objectives of taking possession of the ideal object, object of desire, and or of dominating, controlling the persecutory object. This phenomenon generates in the analyst an affective emotional response, the countertransference (ZIMERMAN, 2004).

Empathy is the capacity of the analyst to feel within himself what is inside the other, to be with the other and feel his pain. This phenomenon of counter transference is very important, however, if there is excessive identification, projective and introjective, it can generate unconscious collusion, that is to say, the relationship between analyst and analisand, unconsciously becomes a kind of corrupt pact (ZIMERMAN, 2004).

Zimerman (2004) says that "every transferencial-contratransferencial relationship implies the existence of bonds". When the projective identification is excessive, it may reach the perceptive capacity of the analyst and affect his conditions of thinking and establishing ideo-affective correlations. The analisand projects himself into the analyst, projective identification, affecting him and provoking in him countertransferencial "blind spots" and a loss of analytic listening. In other words, the analyst ceases to act with his floating attention and awakens his resistances.

On the other hand, the analyst to feel the sensation of erotic desires as a reply to the transference of the analisand, which is called erotic counter transference, is common to happen and can often be useful, however, if both remain impregnated by these desires, these can harm the interpretative capacity of the analyst and this constitutes an eroticized counter transference and can pervert the analytic link. Another example is the somatized countertransference which is constituted in the somatization that

presents itself to the analyst from the contents of the analisand and this may present itself in the form of physical discomfort, sleepiness and other bodily sensations and symptoms (ZIMERMAN, 2004).

The analyst will only be able to deal with the emotional manifestations aroused in him/herself if when perceiving them he/she applies him/herself to investigating him/herself through self-analysis, in order to, differentiate if these sentiments in fact originate from the transference of the analisand or from his own unconscious contents (ZIMERMAN 2004). Zimerman (2004) believes that although both transference and countertransference are an unconscious phenomenon in privileged conditions, it is possible for the analyst to differentiate what was projected onto him from that which is his own. This privileged condition to which Zimerman refers can be explained by quoting an excerpt from Freud's letter to Fliess in (1897), in which Freud alerts to the fact that self-analysis is only possible if the analyst is in analysis.

> "My self-analysis is still interrupted, and I understood what the reason is. I can only analyze myself with the help of objectively acquired knowledge (as an external observer). True self-analysis is impossible; if it were possible, there would be no neurotic disease. Since I still find some enigmas in my patients, they are bound to delay my self-analysis also." (FREUD, 1886-1889, p. 328)

In the excerpt below Freud (1912) says of the crucial importance of the analyst's unconscious in the analytical investigation of the patient's psyche. The analyst's unconscious begins to have a function similar to that of a receptor organ, which demarcates its role as a tool in listening to the patient, or better, in capturing the unconscious speech.

> [...] he must turn his own unconscious, like a receiving organ, toward the patient's transmitting unconscious. It must adjust itself to the patient as a telephone receiver adjusts itself to the transmitting microphone. Just as the receiver transforms back into sound waves the electrical oscillations in the telephone line, which were created by sound waves, so the unconscious of the physician is able, from the derivatives of the unconscious communicated to him, to reconstruct that unconscious which determined the patient's free associations (FREUD, 1912, p.129)

The phenomena presented in the psychoanalytic clinic are often distressing because they are all important in the clinical management. It can be observed in the quotation from Valabrega (1979 *apud* PORTAS, 2003) that many times the pressure of the importance of these phenomena is so great that it can even provoke in the analyst a certain dread:

> [...] everything that the analyst says, everything that he manifests, everything that he lets transpire, understand or guess, the smallest of his acts and gestures, even what escapes him, what he cannot see or understand, in a word, this whole palpable or inapprehensible set in the analysis or at its margins, takes on a superlative importance, which surpasses the unimaginable and sometimes even provokes a certain dread (VALABREGA, 1979 *apud* PORTAS, 2003, P. 21)

Hence the great need for a continuous formation of the analyst that contemplates theory, practice and personal analysis. For in the exercise of analysis, the same phenomenon may present itself as a useful tool as well as an obstacle in the analyst's work (ZIMERMAN 2004).

2 OBJECTIVE

Analyze the countertransference in psychoanalytic clinical management

3 METHODOLOGY

The research conducted in this work is classified as a "Case Study" in psychoanalysis. According to Guimarães and Bento (2008), the path taken by the research analyst must be guided by what is said and especially by what is not said between the lines of what is said. Therefore, case study research in psychoanalysis is imbricated in clinical practice.

> "Case Study" in psychoanalysis is closely linked to clinical experience. First there is the clinical care and then the construction of the meaning of what occurred in the clinical case. Thus, the psychoanalytic theory is being built following the path of the patients' pathos (GUIMARÃES & BENTO, 2008 p. 92).

For Guimarães and Bento (2008) a case study in psychoanalysis is the description of the clinical case and its theorization. This description goes beyond the mere description of the pain and pleasure of the analyzed in writing, in order to evidence the unconscious meaning of the subject's words, actions and imaginary productions.

PARTICIPANTS, PROCEDURES AND INSTRUMENTS

Three interns from the psychology course of the Estácio de Sá College of Goiás (FESGO) participated in this research:

Case 1: NS Trainee Patient: L
Case 2: Trainee LN
Case 3: RS Trainee SV Patient

The procedure used was investigative listening to the reports of cases during the supervised training periods, in order to perceive in which cases the phenomenon of transference and counter-transference occurred. Of the cases presented, three were chosen that best contributed to attaining the objectives of this research. The trainees were invited to participate in this article, and after they accepted, signed an informed consent form.

The instrument used for data collection was the qualitative interview because "the qualitative interview aims to meet the research objectives" (FRASER, GOLDIM, 2004, p.145). The interview configuration is unstructured, the model most used by psychoanalysis, "The psychoanalyst (interviewer) is responsible for offering a differentiated "listening", restricting his interventions to a minimum, only to facilitate the patient's free association" (interviewee) (FRASER, GOLDIM, 2004, p.144).

4 DEVELOPMENT

In case 1 the NS trainee in her first service with patient L had an experience of countertransference. The countertransference presented was a hindrance to the service as pointed out by Freud (1912).

A case report

NS trainee I felt her anguish and disbelief. In some moments the transference was so intense that I countertransferred, producing in me a feeling of anguish generated by the feeling of incapacity and impotence transferred by her. In some moments she even verbalized what I felt through the transference.

Patient L: I don't know if it will work out, I'm full of problems, serious things, and I'm afraid of coming here and just wasting my time, so I realized how it works here with the interns.

NS trainee: She disbelieved in the possibility that psychotherapy could be effective, she passed on a tone of anguish and revolt in her speeches, as if her case had no solution.

Patient L: I am full of problems, serious problems, I don't know if you can help me. My week was not good, starting with my daughter who is full of problems, my son is full of problems, I am full of problems. I expected from her (the daughter) [...] something like you, all cute [...] like this, all delicate.

Intern NS: In that sentence, she identifies me as being a daughter to her, and I transfer to me the feeling of powerlessness, that is, the inability of a daughter to solve her mother's "serious" problem. In another moment she projects onto me things that are her daughter-in-law's and says:

Patient L: She is just like you, a little girl, young face, just like you.

Stagia NS: Because of her transference and in response to the countertransference, it made me feel embarrassed and incapable. At the moment of the service I didn't have conditions to perceive that those contents were not mine but hers. This affected my analytic listening and with this I could not have conditions to interpret her speech and also to make the necessary interventions for the analytic process. The insecurity that I transferred to her through the countertransference caused both she and I to give up on psychotherapy. At that moment, there were no favorable conditions for the establishment of a therapeutic alliance, that is to say, a reciprocal trust between psychotherapist and patient.

In this case, the trainee could not identify that the contents manifested there of insecurity, doubt and distrust, were not her own contents, but the patient's, which were transferred through the projective

identification. The trainee introjected the contents projected by the patient, that is, she appropriated the contents as being hers, and responded emotionally to these projected contents. This countertransferential response reaffirmed in the patient this incapacity, which is part of the patient's own contents.

5 CONCLUDING REMARKS

It is concluded that if the trainee had been able to realize that the feeling of helplessness was not part of her contents but of the patient's she could have made a better and more appropriate intervention using this.

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