COMMENTARY ON "THE COUNTER-TRANSFERENCE AS THE ONLY CLUE"

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The concept of counter-transference remains controversial probably because Freud first regarded it as an obstacle and because we have not yet freed ourselves sufficiently of this notion. Counter-transference represents evoked feelings in the therapist that are not directly the result of the real relationship between him and the patient but remnants of unresolved conflicts from the past. But these are feelings, and as such they are neither good nor bad, neither positive nor negative. Even more importantly, they must not be acted out. They must, instead, be recognized quickly for what they are, observed and put into perspective based upon self-knowledge.

We now know that transference distortions of patients are not an obstacle nor an interference with therapy, as Freud thought at one early point, but rather they provide us with the most useful handle for our work. Counter-transference distortions are similarly capable of providing us with clues about the patient, but only when the therapist is aware of them as soon as they appear, when he can define them clearly, and when he can fit them quickly into the outline of his own remaining pathology. This difficult work must be performed within the framework of a non-pathological, real relationship with the patient.

Counter-transference feelings are a dangerous interference, on the other hand, and they give us no information about the patient at all when the therapist fails to recognize their appearance and nature very quickly and unless he sees clearly how they relate to his unresolved conflicts, and, therefore, keep from being influenced by them. The followers of "Modern Psychoanalysis" in New York have been struggling with this issue for years, often without too much success, (1) although Spotnitz personally has made important contributions in this area. In the absence of clarity on these issues, counter-transference is usually a detrimental interference in the psychotherapeutic process.

This, I believe, is, unfortunately, what happened to Mr. J., who is described so well in the article under discussion. Luis Miller de Paiva recognizes properly that, "It is difficult to interpret with assurance an analytical session (in which one has) not been present." But, like him, I would like to put forward a hypothesis which explains more clearly what has probably happened.

Mr. J., whose father is described as drunken and his mother as possessive and seductive, must have existed in a life-long panic, off and on, for he never really knew an inner sense of true security. Accompanying the sense of impending doom he must also have repressed tremendous rage, always fearing its sudden eruption. This rage, having pre-verbal roots, was probably reinforced by a long series of later disappointments. It was so frightening to Mr. J. because his inadequate parents have essentially failed to help him develop self-control. The boundaries between feeling and acting were not clearly established. He must have expended tremendous energy throughout his life to make sure that he never oversteps the safe limits within which he could control his enormous underlying anger. This is confirmed by how he presented himself "The overt reason for him having treatment was his terror that he was somehow damaging to other people." (p 192) His repeated, contemptuous, jibes at the therapist probably were an unconscious or pre-conscious attempt to force the latter to set firm reality limits. This would obviously be very reassuring to Mr. J. To have referred this patient to another therapist, especially a woman, was a serious error. It was most probably interpreted by the patient as a rejection by Dr. Walbridge, confirming to Mr. J. that indeed he was a monster and, therefore, unsafe. This would only increase his panic.

Mr. J., nonetheless, followed the recommendation. What else could he do in his despair? Again he tells the new analyst indirectly that he is panicking, afraid that his rage might erupt, that he is a monster, that he is dangerous. Rather than hear these as expressions of feelings, specifically

fear, he is believed and taken literally by the doctor and rejected. His worst fears are again confirmed by outside reality and his panic deepens dangerously. We are told that Mr. J. was in reality a mild and scared man, never having done damage to anyone, with lots of bluster to hide his sense of impotence. Yet, the prospective analyst is scared by his empty boasting: "He convinced her he might be liable to rape a woman, perhaps even her, and she declined to take him on." Rather than firmly help him recognize the difference between feelings and actions, his actual demeanor was ignored (the process) in favor of the material which he produced verbally (the content). This, unfortunately, is a common error in many analyses, especially by relatively inexperienced therapists.

He stayed with the group as a second-best but last chance, since his panic must have been almost overwhelming. Twice now his worst (unconscious?) fears were confirmed by the actions of two experts--the group analyst who referred him away, and the individual analyst who did not accept him. He probably did not just stay with the group as reported, he clung to it for dear life. It is not surprising that he would now have a psychotic-like break, inventing the stories about his libertine homosexual and heterosexual encounters. His sense of powerlessness in face of his tremendous rage must have been enormous, and he tried to hide it by appearing potent. But his stories produced fear in at least one patient (Miss Y. was "shocked"), and it appears also to have scared the therapist who allowed another man in the group to be "my champion against Mr. J." (p. 192) It becomes clear why "Mr. J. became largely silent", why "He appeared to be very angry about something, although when people questioned him, he would say he had just decided to listen, " why "the feeling of hostility was intense". (p. 193)

Finally it happened. He did lose momentary control over his rage and smashed a vase on the table in front of a man he was angry at. Even this dangerous outburst was tolerated. It was not addressed as an urgent signal

of danger, and it did not produce a firm re-statement of the limits of acceptable behavior. Feelings were again not clearly and crisply distinguished from actions. As Mr. J. experienced his control as slipping, another psychotic-like break was precipitated. He claimed that he had lost his job (which he had not), his appearance became disheveled and unkept and he made sexual overtures to another patient.

The therapist's counter-transference started long before he forgot Mr. J.'s name. It did not alarm him, unfortunately, but he was, instead, "slightly amused". Someone in the group recognized correctly that Dr. W. had "psychologically killed Mr. J.", and that he "was palming off 'his' responsibility onto Mr. J.". Dr. Walbridge's counter-transferential discomfort also shows when he says that Mr. J. had "factual information about him", when, in fact, the accusations of Mr. J. were inaccurate. The counter-transference was repeatedly and grossly acted out. There was objectively no malice invovled, but since we hold ourselves out to the public as objective experts--this is hardly an acceptable excuse.

Mr. J.'s appearance improved and his panic diminished when the group rallied against the therapist, rather than against Mr. J., thus demonstrating to Mr. J. that he was not in fact a monster. The vase was smashed, but no one else was. Such re-assurance is supported, however, on very shaky grounds and the help it provided Mr. J. must have been short-lived. Working-through has not occurred, and the underlying fears remain intact even if temporarily attenuated.

In a brief paper published in 1977 on the conscious use of counter-transference (2), I have described how the counter-transference can be helpful to the therapist in his work with patients. Such clues are only useful, however, when a relatively intact observing ego is in place, with the help of which almost instantaneous reflection upon one's feelings becomes possible. Under such circumstances the therapist can examine what has happened to

him from the perspective of objectivity. This, unfortunately, is not what Dr. Walbridge describes, but he deserves credit for his candor, which enables others to learn from his mistakes.

The effort to correct the error by burdening the group with the therapist's counter-transference is also of questionable merit. Even if by chance it had a beneficial effect on Mr. J. it probably is an unacceptable procedure, for it might just as well have produced dangerously harmful effects instead. At least one party in the psychotherapeutic dyad must remain objective and sane essentially at all times, for subjective distortions can otherwise never really be corrected. Patients who seeks our help as highly skilled experts have the right to count on therapists to always serve as reliable yardsticks by which reality can be double-checked in moments of doubt.

REFERENCES

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