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COUNTERTRANSFERENCE: THE ANALYST'S RETREAT FROM THE PATIENT'S VANTAGE POINT

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The history of the term 'countertransference' has, in succeeding years, paralleled that of the concept 'transference'. First believed to be something to be got rid of, a hindrance to the treatment, it came subsequently to be viewed as an essential element around which our understanding of the patient pivots. Appreciation of its ubiquity as well as of its potential usefulness arose in the wake of the increasing interest in the participatory dimension of the analytic situation.[1] But whether viewed as help or interference, a unique entrée to the patient's inner world, or an obstacle to hearing its subtleties, there is little dispute that the countertransference must, at least, be located by the analyst in order to further the clinical endeavour.

In sharing my own reflections on this subject, I will discuss aspects of our analytic listening that may help us to discern nuances in countertransference responses not otherwise apparent. In recent years (e.g. 1983, 1986, 1987, 1990a, b) I have been attempting to delineate a mode of gathering clinical data which seeks to minimize leaps of inference we make, and to focus inquiry more rigorously on the patient's inner reality. In sharpening attention to the clinical moment, to shifts in affect or state, and to how these may bear on the patient's experience of the analyst's participation, the patient's self-observation will be strengthened and access permitted to a deepening realm of psychic phenomena.

But I have also noted certain difficulties in sustaining this clinical stance. Despite cogent theoretical and technical agreement that the patient's psychic reality is our 'decisive' domain (Freud, 1917) there seems to be a general inclination to move back, away from the patient's inner world. Unwitting or well-rationalized though this may be, we tend to assume a hierarchical position, in which the analyst, drawing upon her or his own view of what is real, silently becomes the arbiter of the correctness of the patient's view. I would like here to consider further what may produce this tendency to accept our assumptions as truth, and its relationship to our experience and our understanding of the countertransference. I will first review, in some detail, certain such dilemmas I encountered in my work with Mr K, a patient about whom I had previously written (1983, pp. 387–9), and then go on to share briefer clinical illustrations.

Mr K sought help for feelings of intense loneliness. He seemed clearly intelligent but had considerable dyslexic difficulties which had been quite burdensome to him throughout his life. School had been a very painful and humiliating place, heightening his sense of alienation. Although he'd completed a college education, Mr K was able to hold only short-lived and menial employment. He maintained the hope that one day he might again return to school.

In the course of analysis, he became aware of the extent to which his learning problem was deeply entangled in psychological conflicts. Intensifying feelings of loneliness and estrangement, the dyslexia also served as a defensive shield, protecting him from having to grapple

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[1] There is a considerable literature on the continuing evolution of the concept of countertransference. See Tyson (1986) for an excellent recent review. See, also, Gill (1982) for a pivotal expansion of the concept of transference to a systematic inclusion of its participatory dimension.

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'Yeah', he continued, 'I really felt a loss of analysis to me, once I viewed it on the side of school... It was mostly that I interpreted what you said, that important treatment answers would come with my going back to school... It was then that I flipped... that I lost... you... What's bothering me now is that I have this school interview scheduled and I was going to get a haircut... the question, should I go ahead with the interview and if I get accepted have them put my application on file? Or, what if I just felt like saying, "the hell with you" and not go through with the interview?... There's such a strong need in me to keep my hair long, like it stands for rebelling against society... in my college years, I had my hair long and my identity was that... Some people were hitting the books and now they're making money... I guess I'm sad because there seems to be a need in me to be myself in this way... My identity doesn't serve me well...'

Mr K was now in a very different affective mode of relating than that in the preceding sessions. We had yet to explore why that was so, but surely it seemed to have some bearing upon a shift in his experience of me.[2] At this point, I said to him as I then understood it, 'So this is where your loneliness takes hold; you mean, you feel you can't have both, being true to yourself and pleasing society; if you cut your hair, it is to please them and if you don't, you choose for yourself, it leaves you feeling lonely. And so here too, once going to school became a way of doing good for your treatment, you felt you had to choose between that—between me and yourself; choosing the one, you felt you lost something of you; choosing the other, you felt lonely'.

'Yeah', he said, again with intensity. Memories of the past then unfolded spontaneously, as he reflected on how his loneliness grew from this sense of having to relinquish a feeling of 'connexion' to mother to maintain what he felt to be the 'essence' of himself. He came to see how this 'connexion' had become linked with a hidden and protective female identity, contrasting with the solitary sense of his masculine self, a state compounded by the seeming unavailability of his father's respectful recognition. Masculinity, learning, and a lonely independence were unconsciously equated. Thus, with the feeling that something of the essence of his experience had been recognized—by me and within himself—in a way that had not previously happened and with no implication that it was awry, a pervasive, underlying sense of confusion began to lift for him and the world took on a clarity he felt he had not before known.

Mr K applied and gained admission to the school of his choice. Some years after termination he wrote to me of having gone on to a successful career and a happy marriage and fatherhood, and that the aftermath of his analysis was a feeling of a sustained and profound sense of inner fulfilment.

The question I had asked myself at the time was: why had I failed for so long to understand that Mr K's massive regression was centrally interwoven with the way he was perceiving me—that my interventions, silent or stated, had been having an essential impact on his ensuing state? I had believed I was making every effort to include my own participation when elucidating the transference; yet repeatedly, I had delayed recognizing this intrinsic relationship. Was there a specific countertransference interference preventing me from hearing the nuances in Mr K's communications, leading me to an enactment instead?

But as I reflected further, I saw a parallel delay in my work with other patients. I noticed a tendency to look at the psychic stirrings within the patient, basically set apart from and outside my participation. And as I listened to clinical material shared by others, I observed that such reluctance to consider the centrality of the analyst's contribution specifically from the vantage point and as an inherent part of the patient's *intrapsychic* experience, has more far-reaching implications.

Re-reading Freud's stirring Postscript to the

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[2] Sander, responding to this material from the viewpoint of infancy research (1989), speaks of the central developmental and therapeutic importance of 'moments of recognition', in which the patient 'becomes aware that another is aware of what he is aware of within himself'. Such 'specificity in recognition', which, he states, is more sharply attained by a listening perspective attending to subtle shifts in state, 'sets the conditions for a change in organization by providing a new base from which the patient can act as agent in his own self-regulation'.

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Dora case (1905), the following words stood out:

This happens to be by far the hardest part of the whole task ... Transference is the one thing the presence of which has to be detected ... with only the slightest clues to go upon ... when the first dream came, in which she gave herself the warning that she had better leave my house, I ought to have listened to the warning myself. 'Now,' I ought to have said to her, 'it is from Herr K. that you have made a transference on to me. Have you noticed anything that leads you to suspect me of evil intentions? ... Or have you been struck by anything about me or got to know anything about me which has caught your fancy, as happened previously with Herr K.? Her attention would then have been turned to some detail in our relations, or in my person or circumstances ... But I was deaf to this first note of warning ... In this way the transference took me unawares, and because of the unknown quantity in me which reminded Dora of Herr K., she took her revenge on me as she wanted to take her revenge on him ... (pp. 118–19).

Easy to take us 'unaware', having to be detected by but 'the slightest clue', of 'some detail in our relations or person or circumstances', Freud wrote as though warning us, lest we too find ourselves 'deaf' to these first notes of the transference.[3] Though he did not pursue the rationale for such a predicament further, it is here, his Postscript implies, that the analyst may go awry—in failing to heed such subtle indicators of the patient's perception of him or of her. Here, I suggest, may lie the source of the obstacle which I eventually observed within myself—my reluctance to recognize my unwitting participation in another's ongoing inner experience—my unwillingness to acknowledge that the truth I believe even about myself, in any given moment, is my own psychic truth, no more real than the patient's, whose view may be different and so, unsettling (McLaughlin, 1981). Feeling a lack of concordance with my own sense of myself in this episode with Mr K., I retreated from acknowledging his point of view, remaining instead within my own.

When I first wrote of this, I supposed that the broader implications in such a retreat related to a matter beyond a consideration of the specificity of the countertransference. I have since come to believe the opposite—that it is precisely some fundamental resistance, *of which we may not even be aware*, to perceiving the legitimacy of another's perspective, that denotes a countertransference interference.[4] Relating this idea to Freud's implicit warning about our neglect of the 'unknown quantity' within ourselves, the unrecognized countertransference may be seen to impede in just this way: some issue surfaces, which, for any one of us, in any given moment, may stir a singular, perhaps idiosyncratic vulnerability, which, in turn, augments an underlying, even if unrecognized inclination to guide the patient, however gently, to a truth we presume we already 'know'.

With Mr K, I believed my interventions were value-neutral, benign and openly inquiring; I believed my attention was 'free-floating'. I did not wish to think that I was culpable of being viewed differently. Any feeling he may have had to the contrary must be a 'distortion,' I reasoned, arising from his need to defend against further elaboration of his anxiety-arousing sexual conflicts. That the transference included such a noxious view of me was inevitable, I further presumed, serving as a central component and demonstration of *his* resistance to exploring these threatening conflictual matters. In this mode of listening, I could allow the awareness of the impact of my own contribution to recede, and thereby step away from the patient's vantage point to sustain the belief in the greater wisdom of my own.

Subsequently, after I had relocated his field of view, I could proceed again with my self-inquiry. Why hadn't I heard him sooner this time, why was I 'deaf' to his 'first notes of warning'? Was there some particular issue here that I might have wished to bypass? He had later said I was not interested primarily in the 'essential' him, as though I'd had my own agenda for him. On reflection, I had to acknowledge to myself that, though Mr K had often said he'd wanted to live in the Western plains and play the banjo, I

[3] I have noted elsewhere (1985) that this description of his discovery of the transference—our participation intrinsic to the field observed, the observer central to the experience of another—may be seen as reflecting the embarkment of depth-psychology upon the modern scientific era.

[4] 'We have become aware of the "counter-transference", which arises in [the physician] as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize this counter-transference in himself and overcome it' (Freud, 1910, p. 144).

inwardly believed it would be good for him to go to school, to continue with his studies—especially since he himself had also expressed this wish. Much as I thought I had attended only to his inner experience, I did have a preference about how he was to live his life, based perhaps on a middle-class value system, well hidden from myself, one I could rationalize as serving the analytic pursuit, and as helping him resolve his sexual conflicts.[5] Here then, lay my particular vulnerability.

I should emphasize that though it may serve important self-analytic functions to be able to find some agreement within me with his complaint, my ability to do this is not the relevant factor in listening to the patient. Indeed, I must be wary lest I use my self-reflection to make judgements about the correctness of his position. For *his perception of me is neither more nor less valid, based on what I am able to find within me.* His view holds regardless, and is the one reality the truth of which is our domain, and the logic of which it is our task to discover. Once we recognize this, it may then appear self-evident, as perhaps his view of me may have seemed to anyone reading the vignette. But this only demonstrates that we have found our way into the patient's perspective.

It is a truism that we say what we do with one conscious intention, in the hope that it will facilitate the analytic process; yet the patient may experience it differently, and in a way that we did not anticipate. Mr K's ambivalent response to my comment that it might be good for his analysis if he were to go to school may have been betrayed by the fact that his initial agreement was qualified: 'maybe', he'd said; blandly, I realized only in retrospect.

Had I not had an unrecognized interest in pursuing my own direction, I might at that time have been willing to take the detour and ask, why that flat answer? If I had then learned how he had perceived my intervention, I could have wondered about the nature of and the reason for his particular, perhaps defensive reply. Why, for example, did he seem, even if with some ambiguity, to agree with me? Did he not know what he felt? If not, what might that mean? Or, was he afraid to differ? If so, had he felt some ground for that fear deriving from his perception of me?

Thus, Mr K may have presented his predicament about school and sexuality in a singular way that stirred something in me, which then led me to respond in a way that served as a familiar re-enactment for him—a bypass of the 'essential' him. But whatever the basis for my intervention, that in itself would not yet have posed a countertransference obstacle, provided I had remained open to the quiet cues. I did not pick up the patient's early bland reply; I did not later think of his regressive behaviour as related to his perceptual experience of me, nor did I hear his communications about *my* messages. I was 'deaf' to these notes of 'warning' because they represented a challenge to the view I held about myself, and to an agenda I held for Mr K which I was not ready to acknowledge, let alone give up. It is this unrecognized retreat from the patient's perspective which, I would argue, marks the countertransference as having become an impediment.

It is, of course, an interesting question—what finally permitted me to hear him—which, as I have said, occurred before I had arrived at the self-awareness I have described? (Indeed, my self-discovery took place only after I had shifted in my listening to him.) It may be that he simply cried louder until I could dismiss him no longer. If so, fortunate for him that he was willing to risk that; perhaps he'd learned, from his experience in the past or with me, that though I might be dense, I would keep on struggling to hear him. To infer that he needed to play this scenario out with me for some period of time as part of an old repetition, would be to attribute a motive—albeit unconscious—to his behaviour for which we do not have the data, and would serve to get me 'off the hook'. The data more likely suggested that it was hearing the patient's

[5] 'It is... no more than a natural ambition if [the doctor] endeavours to make something specially excellent of a person whom he has been at such pains to free from his neurosis and if he prescribes high aims for his wishes. But here again the doctor should hold himself in check, and take the patient's capacities rather than his own desires as guide' (Freud, 1912, pp. 118–19). Though I am here speaking to inclinations rather than specifically 'capacities', it should be noted that Freud used the word '*Eignung*' (Gesammelte Schriften, 6, p. 73) which might be translated as 'suitabilities', or as something of 'one's own'.

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State

cues sooner rather than later which deepened the analytic inquiry.[6]

Sometimes, the cries of our patients soften; insight may seem to have been acquired, conflictual or other symptomatic behaviour relieved, yet a deeper hope may be quietly given up. This poses a greater challenge, for we must then be willing to forego our own gratification in the apparent progress to question the muted tone.

Mrs E came in furious with her daughter's employer for the way he treated her. Ann, her daughter, had, on a whim, chosen not to perform a particular assigned task; her employer, having given warning of the consequences of such inaction, was punitive. Ann protested angrily, and the patient was proud of her ability to do so. Mrs E's strong conviction about the employer's unfairness was striking in this usually more hesitant and cautious woman. I wondered, what had she herself felt about her daughter's behaviour? Might she, on some level, have felt critical or reprimanding of her? 'No', she replied, 'a kind of chuckle, perhaps; only sorry she got caught'.

Thinking more about this, Mrs E began to recognize that she drew an added pleasure from Ann's taking this assertive, even rebellious path; it was one she herself would not dare to follow. I felt interested, even somewhat gratified, at the patient's ability to reflect that she might indeed be using her daughter for her own purposes, to 'act out' against her own inhibitions.

In the next session, the patient returned to a more uncertain and guarded state, and did not speak further of Ann. The anger she had expressed had apparently dissipated. As the hour progressed, her hesitation increased; she sighed frequently, spoke more softly, and interrupted each sentence with pauses. I asked about the return—indeed, the intensification—of this state. Now, reflecting on it, she felt she could recognize and acknowledge that she had been wanting me to admire Ann for her 'spunk'.

'Oh', I responded, 'and I didn't do that when I asked whether you might have felt critical of Ann for her behaviour'.

'I think, now, that I felt you were saying I wasn't a good mother', she cried. Her speech regained its fluency, and she then began to talk more audibly about what this meant to her—to be a good mother.

Striking! The fluctuation in her manner of talking bore directly on how she was experiencing my interventions. Feeling that her wish for her daughter to be admired had gone unheeded, she became hesitant and tentative, reflecting a change in her state. Further, precisely because of this faltering state, learning about this experience as it occurred within the analytic hour was particularly difficult. At first she had not even been aware of the style of her response; it was I who first called it to her attention, asking what it might mean. This question then helped her to recognize and articulate her previously unconscious wish, and the rebuff she perceived from me; after that, she regained her fluency.

In the succeeding hours we talked more about her style of relating—non-verbally, instead of with a directly expressed rebuttal of me. 'Criticism of you would risk my losing you', she elaborated, with still to be added historical dimension.

The question returns: might there have been a shift earlier, more subtly expressed, in the very session in which she felt criticized? If so, why had I not picked it up at the time? Perhaps, if there was such a delay, it was due to *my* investment in having her learn what was essentially *my* agenda, something *I* thought was important for *her* to see, i.e. the use she was making of her daughter. Since she apparently went along with me, it might be that I had failed to attend to any possible change in her mode of talking—the non-verbal expression of her resistance to going in the direction I had taken. Thus I could discover a dimension of my experience—the preferred pathway I had chosen for internal reasons of my own—that I might otherwise have overlooked.

Perhaps, in still earlier sessions, there were other faintly evident variations in her state and in the degree of her hesitation, which I allowed to pass unnoted, to keep the flow going in a 'known' direction.

[6] 'There was, I suppose, a time', a patient once said to me, 'when I couldn't put into words what I was feeling ... *if only someone had recognized it*'.

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Sometimes, our patients make their feelings more directly known, in ways that may become so intense and immediate that we are at risk of stepping back, to regain for ourselves what we may feel to be a more comfortable distance.

In one session, a patient was talking without much affective colour of various things—some, memories of his mother, depriving, seductive (see also Schwaber, 1990b, pp. 235–6). I was quiet; he went on. Then he said, with a sharp affective presence, 'I have this feeling I want you to hold me'. 'Just now?' I asked. 'Yes.' Thinking of what he'd been saying about his mother, I asked, 'Did she ever hold you?' 'Not really', he replied, and then spoke, poignantly, of how, when he was little, he would go into her bed and just watch her breathing while she was asleep; at times, he'd put his arm around her...'What made you feel this now, with me?' I wondered. 'An emptiness', he answered, without elaboration, and his associations went back to mother and to his girl-friend.

During the next session he spoke of an intense longing he'd felt the previous day for a warm greeting from his girl-friend—a painful yearning for physical contact; he had even felt it at a meeting with female co-workers, just wishing he could hug them. He spoke of how terribly hurt he'd been by his girl-friend's apparent rebuffs; when he came home she seemed tired and preoccupied, while he wanted a more loving response. I wondered what might have happened that intensified this sense of hurt—since the session, perhaps? He replied, 'Something bothered me here; when I said I wanted you to hold me, you shifted to my mother. I felt you were uncomfortable. It was useful talking of my mother as I did, but you shifted right to her. You've often pointed out how I do that; now you did it'. 'Oh' I said, 'so you left the session still looking for a hug—not met'. He agreed.

I pondered this. I was not aware of it at the time I asked, but now I could see that my question, 'Did she hold you?' lay outside his intrapsychic domain (i.e. outside the sphere of his immediate experience), and did indeed seem like a leap away—having its parallel to the near but depriving mother. But why had I moved away like that? Perhaps it had something to do with the unexpected vigour of the wishes expressed towards me. I was taken rather off guard. At first I did ask, 'Just now?' But then I quickly shifted to mother, only later returning to the transference. As the patient indicated, I'd usually been the one to point out his tendency to retreat to mother away from me; now I was guilty of the same.

I thought about this hour as I listened to other clinical presentations: our thresholds will vary, but there is perhaps a general tendency to shift away from the immediacy of the moment—whatever the nature of the feelings expressed—away from a pointed focus on a single clinical instance as it is taking place. Even a seemingly open question, as when I asked, 'Did she hold you?' can be used to keep knowledge away. We may thus spare ourselves the intensity of the patient's pain or wishes, of the closeness, and keep away from resonance with our own pain or wishes. It is this inclination for affective distance which may lead us to favour the certainty of our own truth—a discomfort, for it means staying with the depth of the affect, sustaining our inquiry into the patient's reality as our singular domain.

Thus I left my patient's inner world when, for a moment, his affect conveyed such a sense of urgency, his words were so stark, that I listened, thinking only of some literal event. I had lost touch with the play of psychic possibility, and distanced myself from him. More important, *I did not know that I had*. It was when I later asked about the subsequent change in his feeling state, when I was willing to forgo preconception about its meaning, that he then observed and described it to me.

And with the passage of time, we learned in more detail of the re-awakening of an old feeling of emptiness arising out of some sense of my non-responsiveness, which in turn evoked an old sense of past non-responsiveness. Each occasion—past and present—was followed by intensified physical yearning, often with a strong erotic component. We might recognize such a sequence by first noting an allusion to the yearning, or a change in his affect; eventually, he could observe his own shifts in state as they were taking place—in the hour, outside, in the lost and not so lost past. And with the elucidation of the meaning of these shifts, and their connexion to how he experienced my interventions—however differently I may have felt I intended

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them—the interpretation of his conflictual issues and the interwoven fantasies which he elaborated became richer and more complex.

Mr B, a man who was rather inhibited about expressing any sexual wishes towards me, cautiously began, after we had been working together for some time, to share them. Several days after that, he said he wasn't sure what to talk about—everything was going okay, nothing special to say. It seemed he was resisting further associations to his sexual feelings. This state continued in the succeeding sessions and I noted that he also spoke in a kind of blunted tone, which was not usual for him. I asked him about this and he recalled a fantasy which he began to share, 'caressing your head, in bed... that's making me anxious—right now... Now, thinking about it, I feel my feelings back... The anxiety is in telling it to you, that you don't want to have that, that you're repelled by me'. How is that?—I wondered to myself. I then recalled and shared with him that this reminded me of what he'd said in a recent hour—that I seemed to him to have backed away as he approached me in the waiting room. 'Oh', he said (almost interrupting me), 'when you said that if you'd stepped forward that would have made me anxious too'. Let me explain: the previous week he had talked of how threatened he felt by the emergence of sexual feelings towards me. Then, in one session he said: 'When I pass you walking in, I feel like you step away... I feel like I want to grab you, sexually... what would I feel if you didn't step back?' And I had replied at that time, with a question, 'Scared?' Yes, he agreed, though he liked these sexual stirrings. Now, in this present hour he said: 'You know, when you said that last week, it was like you'd said, "See, you're frightened of me; there isn't room either way, for me to step forward or back". It was like you were saying I couldn't handle your sexuality, not that your sexuality is so overpowering, but that I can't handle it'. 'Oh, my words meant I was saying "you're not man enough"', I now could see; 'that's why you'd be scared either way, whether I move back or I move forward'. 'Yes... just like my mother, always emasculating me... I now realize, I felt put down by you, but I accepted it, as though it was not a dissonant statement, but so familiar.' He continued to speak, spontaneously, of the distant and the more recent past, of times of sharp humiliations and belittlements, as his sexual feelings and conflicts were re-awakened. In other words, something about my question—'Scared?'—evoked old hurts; he made this clear now.

To review what had happened, after his guarded expression of sexual fantasies, I noted that something had gone awry; Mr B no longer felt there was anything in particular on which he wanted to work, and he sounded somewhat flat. At the moment, this was all I knew; a resistance had occurred, and I inquired about it. Strikingly, this very inquiry seemed to permit his sexual feelings to re-emerge. But as he then began to recount his fantasy, he again defended against it, imagining me as repelled by him.

This reminded me that he'd recently described another experience of feeling rejected by me (when he felt I'd stepped away from him in the waiting room) and I now shared this with him. This time, rather than appropriate his meaning by ascribing his perception of me in the transference—as potentially repelled—to a defensively motivated distortion, I simply asked more about where it might have arisen. It was then that I learned I had made an intervention which felt to him like a put-down of his sexuality. That was the context in which his resistance emerged, and which I could then interpret.

When he explained it, I could see how my response to him might indeed be given the belittling meaning he attributed to it; like finding the solution to a maze, it became rather obvious, an indication that the logic of his vantage point had been detected. An alternative intervention, like asking him what he thought about his question, rather than suggesting an answer—'scared'—might have been wiser. I must, then, ask myself, why had I not done that? It may be, I now feel, that I was reluctant to chance his answer that he did indeed want me closer than he felt I wanted to be. In pre-empting his reply, I could shield myself from having to share in his experience of rejection by saying, 'Perhaps it is you who doesn't want me to step closer to you, rather than I who am stepping away'.

This retrospective opportunity to second-guess my intervention was provided by my question about the shift in the patient's state. His defences arose in relation to his emerging

sexual wishes, to be sure, but my specific participation bore directly on his retreat, and was brought back into focus when I asked about his muted tone—that is, when I was able to relinquish my preconception in order to move in an uncharted direction. Then we could see, the patient's resistance occurred within the context of my response to his sexual stirrings re-evoking a familiar sense of an old response to old stirrings. (I emphasize the idea of 'sense', because we can speak of his mother's response only from the vantage point of his perceptual experience, as he conveyed it in the present; Schwaber, 1986.) The transference included my participation—*as he perceived it*—intrinsic to its formation. And again, experiencing this sense of familiarity and affective recognition, he felt reinvested in the analytic work.

In a last vignette, I will try briefly to illustrate a moment in which I was aware of the struggles within me, as they were taking place—an awareness which helped me to return, sooner, towards recognition of the patient's vantage point.

Two sessions before the summer break, Ms T was quiet much of the time. Then, in the last year, after a period of silence, she spoke of her worry that something might happen to me and that I would not return. She stopped again and then said, 'You're always more quiet before you go away. I want you to talk to me and you don't and I get angry. Before you go away, I want to establish a stronger connexion and I feel you want to establish more distance'.

Isn't this strange? I thought to myself. She's the one who became quiet and yet saw me as doing that. She's the one who seemed to be distancing herself, but saw me as doing. Was she placing her feelings on to me, or trying to get me to feel what she felt—angry and unresponded to—so I might know her feelings that way? I had no awareness of being particularly quiet or distant. My sense of myself was jarred. I was certain that I was not the one who was retreating.

It would be easy now to find an explanation; after all, I was going away. That could be reason enough for her to have experienced my response in this 'distorted' fashion—a projection of her own withholding feelings—for her to focus her anger on some other injury, so as to deflect the pain of our imminent separation. But such reasoning would imply my own contribution in this moment wasn't essential to her perception, which was rather pre-determined; and further, that I'd already understood the meaning of her experience—and maybe I had not. It would be making a leap of inference for which I did not yet have directly observable data.

Let me resist the temptation for closure, listen more to what she's telling me, about me, and see what I might yet learn. Interestingly, once I shifted in my listening stance to see her vantage point, a subtly perceived sense of struggle with her eased, for I was no longer trying to change her view. I could recognize that, though I had believed myself to have been respectfully and appropriately waiting for her associations, my wait alone might have made me seem the quiet one, certainly not as reaching out.

And so, in response to her saying that what she wanted was to establish a 'stronger connexion' before I went away, I commented, 'It seems you're wanting me to reach more actively to you'.

'Yes', she said, unhesitatingly, her tone now seeming more relaxed.

'Why then do you become what seems to be more quiet at this time?' I asked—noting that there appeared to be a certain defensive style on her part and trying to understand this better. 'As you say, it's not to establish more distance.'

'Maybe it's just if I talked', she reflected, 'then I wouldn't know if you really meant it when you responded'.

'Oh, so you look for something *more* from me, especially before we separate, to show my continued involvement', I commented.

'Yes ... I feel the same way about George [a friend], before he goes away ...' Her associations continued; 'It's also hard for me to reach out; I only do that in desperation really, because I don't want to run any risks'.

'Of reaching and finding no one, which are greater before a separation?' I wondered.

'Yes', she said, 'It always feels to me that I just have to be there or I don't really exist ...'

This time, I had resisted my inclination to teach, and sought instead to learn what I did not yet understand, about her and perhaps about me too. Ms T, in turn, opened a new direction about the nature of her experience—her feeling of not existing in the other's absence, the increased risk

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before a separation. In subsequent hours, elaborating memories from the recent and distant past, as she felt her perceptions recognized, she came to distinguish and acknowledge, on her own, additional nuances in the history of her defensive stance—her uses of quiet and retreat, and their relationship to her conflictual issues.

To be sure, in taking the approach I did, she may have experienced me as reaching more to her—the very thing she had wanted in the first place. But that too is still uncertain, for, until it is explored, who is to be the judge of what constitutes more and what less? Whichever it may be, listening in this way helps us to learn about just these vicissitudes—when she feels more reaching out, when she feels less, and also when this dimension of response is not of immediate concern to her.

I have tried to illustrate the added opportunity to discern certain perhaps ubiquitous dilemmas which surface in the effort to sustain the focus on the patient's psychic reality, and which, in turn, will help us to locate our countertransference. I have not here considered those instances in which I spontaneously recognize a countertransference difficulty within myself *before* becoming cognizant of a cue from the patient—as when I'm aware of feeling angry or irritated, bored or too much identified, even if these scarcely manifest states may at other times be the first clue to me that I've stepped outside the patient's shoes, (or, as in the case of Ms T, when my initial vaguely-felt sense of struggle contained the potential for me to do so.)[7] Nor have I addressed those moments in which I observe myself in some form of enactment with the patient. For if it should occur that I unwittingly assume a kind of parallel 'role-response' (Sandler, 1976a, b) I generally find, retrospectively, that there had been a preceding 'note of warning' (Freud, 1905) about some dimension of the patient's experience left unattended—such as Mr K's bland 'maybe'. Indeed, it is often after some earlier communication has been overlooked that the patient will draw back, and *then* re-create what may be an old, regressive or more insistent behaviour.

Thus, I have undertaken to examine ways of enhancing our attunement to subtly expressed clues from the patient, even when this requires a shift in our inquiry that may seem to be a digression from the issue in hand. Attending in this way may help us to recognize a moment of retreat from the patient's field of view, and to observe a meaning given to our communication—silent or stated—which may not otherwise have occurred to us. We may thereby alter or broaden our own perspective.

I try to find the patient's world, and in so doing, seek resonances with my own—a mode of listening Gardner (1983) has eloquently described. For our resonances of mutuality allow us then to discover our differences. I try to find a way to distinguish between what belongs to my reality and what to the patient's, and repeatedly I stumble, seeing only through my own, pre-fixed lens. The particular ways in which I do—what the patient may evoke in me—may offer important data yet to explore. As illustrated, they may recreate ways others too were felt to be responding, and concomitant patterns of interacting and defending that the patient had in turn

That we bring ourselves, our preconceptions, our models to the patient, does not of itself create a problem. On the contrary, our participation enriches our field of inquiry, for perception is an essential part of the patient's psychic experience and therefore of the data we must gather. We impact on one another in ways that may repeat and that may change the other. But what is essential is that whatever our impact, *it is from the point of view of the patient that its exploration and elucidation assume the central focus*. This is in contrast to an interpersonal position which draws upon the analyst's or other outside observer's vantage point, to co-determine the meaning of his or her participation.

Sander (1962, 1983, 1985, 1987) highlights the need to seek the logic of the patient's 'state

[7] Jacobs (1986) writes vividly of the need for awareness of scarcely visible manifestations of countertransference reactions which may remain rationalized and unheeded. I am suggesting here that a rigorous effort to sharpen the focus *on the patient's reality* would help us to recognize such manifestations within ourselves even earlier.

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regulatory strategies' which in turn will help us discern an added dimension to our participation, offering a further inroad into the patient's past. When countertransference interferes, we may fail to explore the patient's experience of our participation in such 'strategies', pulling back instead to the assumed role of arbiter of the 'correctness' of the patient's perception: is it 'true' or 'distorted?'

If, then, there is a discrepancy between my view and the patient's, I must ask the question, do I now use this difference to guide the patient, however subtly I may do so—in my direction, or even to arrive at some compromise between us; or is it rather evidence of something I have yet to learn, which I don't now understand? If I say a patient is 'demanding', 'withholding', or 'provocative', do I recognize these as simply describing behaviour as it appears to, or as may be experienced *by me*—which does not yet tell me what the patient feels? Countertransference interferes when, knowingly or not, I won't let go of the supposed greater wisdom of my own vantage point.

Countertransference impedes at those moments which vary in accord with our own individual vulnerabilities or proclivities. Sometimes it is the particular issue touched upon which limits our capacity to tolerate uncertainty; sometimes it may be that we are tired, or preoccupied, don't have the energy to chart new pathways.[8] But within each of us there may lie, more or less, a predilection to answer rather than to ask. In assuming this stance of 'knowing'—even about ourselves—what is the 'correct' reality, we implicitly maintain an agenda for what we hope our patients will achieve. Thereby, we depart from the play of psychic possibility and lose the psychoanalytic vantage point.

At the meeting of the American Psychoanalytic Association in Montreal in 1988 (Schuker, 1990), members of a panel were given the process notes of the first week of an analysis and invited to respond by imagining the second week, as though each were the analyst. As a panellist, the task at first seemed impossible to me, yet also intriguing and paradoxical. I argue that we tend, albeit unwittingly, to create our patients in accord with our own agenda, and now I was being asked to do just that—to invent the patient's words and feelings. I was going to have deliberately to design instances in which I wasn't hearing the patient, in order to demonstrate this very tendency, and ways of listening for it. So, I believed, the invented second week, with all my ascribed departures from the patient's vantage point, was under my control—at least consciously so.

I then read my invented sessions to a colleague, to see whether he felt I had remained true to the patient's material as shared in the first week's protocol. To my surprise, he pointed out that I seemed to him to have my own agenda for this patient, of which I hadn't been at all aware. Citing evidence for how I was trying to get her to look at her conflicts about her female identity, he showed convincingly that I was inattentive to the possibility that even her fabricated responses to such interventions were ones of compliance. I realized that one always needs another person for such a corrective; lacking a live patient, I had to seek it from someone else. That is what our patients will offer us, if we but heed them.

Summary

As analysts, we may agree with certain basic tenets: we should not impose our truths, whether or not theory-laden; we should maintain the focus on the patient's inner reality, not on how he or she lives in the world—out there; we should be prepared to be surprised, to learn something that hadn't occurred to us; we should look for multiple cues in the clinical data, pay

[8] Some time ago, after my father died, several of my patients responded in a way that finally conveyed to me that they felt I was affectively more distant. Paradoxically, and perhaps to compensate for any such possibility, I had tended to be more active, more attentive to how they were living their lives—'out there', so that I might be of 'more' help. Still, a sense of my distance was felt.

There are a number of excellent papers on the subject of illness in the analyst, e.g. Abend (1982), Dewald (1982), Lasky (1990), Schwartz (1987) and van Dam (1987), as well as Givelbar & Simon (1981), on a death in the therapist's life.

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attention to affect and state as may be expressed within the moment, and listen for subtleties that may convey something about how we are being experienced in the transference.

But again and again, we fail to adhere to these precepts. Despite our best intentions, we seem to have a fundamental disinclination to maintaining these positions. I have tried to consider some reasons for this difficulty and its relation to the countertransference. Drawing upon several clinical examples, I have attempted to examine ways of enhancing our attunement to verbal and nonverbal cues from the patient which may direct us, sooner, to dimensions of our countertransference responses otherwise overlooked.

Translations of Summary

En tant qu'analystes, nous pourrions sans doute convenir de certains principes, à savoir: nous ne devrions pas imposer nos vérités, qu'elles soient chargées de théorie ou non; nous devrions nous en tenir à la réalité psychique du patient, et non à la façon dont il ou elle vit dans le monde, au-dehors; nous devrions être prêts à être surpris, à apprendre quelqhechose qui ne nous était pas auparavant venu à l'esprit; nous devrions chercher à découvrir des indications multiples dans les données cliniques, faire attention aux affects et aux états tels qu'ils peuvent être exprimés à un moment donné, et chercher à saisir les subtilités qui peuvent nous communiquer quelque chose sur la façon dont nous sommes perçus dans le transfert.

Cependant, à maintes reprises, nous n'observons pas ces préceptes. Malgré nos meilleures intentions, nous semblons avoir une répugnance fondamentale à maintenir ces positions. J'ai essayé de considérer les raisons de cette difficulté et ses rapports avec le contre-transfert. En me servant de plusieurs exemples cliniques, je me suis efforcé d'examiner les moyens qui pourraient nous permettre d'accroître notre capacité à capter les indications verbales et non verbales du patient, lesquelles peuvent nous mener, plus rapidement, à certaines dimensions de nos réactions de contre-transfert qui autrement seraient passées inaperçues.

Als Analytiker sollten wir uns über die folgenden grundlegenden Regeln einig sein: wir sollten niemandem unsere Wahrheiten aufzwingen, ob diese nun theoriebeladen sind oder nicht; wir sollten den Fokus auf die psychische Realität des Patienten richten, und nicht darauf, wie sie oder er in der Welt lebt; wir sollten darauf vorbereitet sein, überrascht zu werden, etwas zu lernen, auf das wir nicht selbst gekommen sind; wir sollten klinische Daten auf vielfache Hinweise untersuchen, dem momentanen Ausdruck von Affekt und Zustand Aufmerksamkeit schenken und auf Subtilitäten achten, die uns Aufschluß darüber geben könnten, wie wir in der Übertragung erlebt werden.

Dennoch halten wir uns häufig nicht an diese Regeln. Trotz unserer besten Absichten scheinen wir eine fundamentale Abneigung gegen die Aufrechterhaltung dieser Positionen zu hegen. Ich habe versucht, einige Gründe für dieses Problem und seine Beziehung zur Gegenübertragung in Betracht zu ziehen. Unter Inanspruchnahme mehrerer klinischer Beispiele habe ich versucht, Wege zur Stärkung unserer Offenheit gegenüber verbalen und non-verbalen Hinweisen vom Patienten zu untersuchen, die uns schneller auf anderweitig übersehene Dimensionen unserer Gegenübertragungsreaktionen aufmerksam machen.

Como analistas quizá estemos de acuerdo con ciertas formulaciones básicas: no deberíamos imponer nuestra visión de la verdad, esté o no cargada de teorías; deberíamos mantener el centro de atención en la realidad psíquica del paciente, no en cómo se conduce en el mundo; deberíamos estar abiertos a la sorpresa, a aprender algo que no se nos había ocurrido a nosotros; deberíamos buscar múltiples pistas en los datos clínicos, prestar atención al sentimiento y al estado que se expresan en cada momento, notar los matices que pueden decirnos algo de cómo se nos percibe en la transferencia.

Sin embargo nuestra adherencia a estos preceptos falla repetidamente. A pesar de nuestras bonísimas intenciones, se diría que en el fondo no nos sentimos inclinados a mantener esa posición. He intentado considerar algunas razones de esta dificultad y su relación con la contratransferencia. Sirviéndome de ejemplos clínicos examino modos de mejorar nuestra habilidad para captar pistas verbales y no verbales del paciente, que pueden dirigirnos con más prontitud a dimensiones de nuestras respuestas de contratransferencia que de otra forma no habríamos notado.

References

Abend, S. M. (1982). Serious illness in the analyst: countertransference considerations. *J. Amer. Psychoanal. Assn.*, 30: 365–380.

Davies, R. (1972). *The Manticore*. New York: Viking.

Dewald, P. N. (1982). Serious illness in the analyst: countertransference and reality responses. *J. Amer. Psychoanal. Assn.*, 30: 347–364.

Freud, S. (1905). Fragment of an analysis of a case of hysteria: part 4, postscript. *S.E.* 7.

—— (1910). The future prospects of psycho-analytic therapy. *S.E.* 11.

—— (1912). *Ratschlage für den Arzt bei der Psychoanalytischen Behandlung*. Gesammelte Schriften, 6. Translated as: Recommendations to physicians practising psycho-analysis. *S.E.* 12.

—— (1917). *Introductory Lectures on Psycho-Analysis*. *S.E.*16.

Gardner, M. R. (1983). *Self Inquiry*. Boston/ Toronto: Little, Brown.

Gill, M. M. (1982). *Analysis of Transference. Vol. 1: Theory and Technique*. New York: Int. Univ Press.

Givelbar, F. & Simon, B. (1981). A death in the life of a therapist and its impact on the therapy. *Psychiatry*, 44: 141–149.

Jacobs, T. J. (1986). On countertransference enactments. *J. Amer. Psychoanal. Assn.*, 34: 289–308.

LASKY, R. (1990). Catastrophic illness in the analyst and the analyst's emotional response to it. *Int. J. Psychoanal.*, 71: 455–474.

MCLAUGHLIN, J. T. (1981). Transference, psychic reality and countertransference. *Psychoanal. Q.*, 50: 639–664.

SANDER, L. W. (1962). Issues in early mother-child interaction. *J. Amer. Acad. Child Psychiat.*, 1: 141–166.

—— (1983). Polarity, paradox, and the organizing process in development. In *Frontiers of Infant Psychiatry*, ed. J. D. Call et al. New York: Basic Books, pp. 333–346.

—— (1985). Toward a logic of organization in psychobiological development. In *Biologic Response Styles: Clinical Implications*, ed. H. Klar & L. Siever. Monograph Series of the American Psychiatric Press.

—— (1987). Awareness of inner experience: a systems perspective on self-regulatory process in early development. *Child Abuse & Neglect*, 11: 339–346.

—— (1989). Discussion of 'Countertransference: the analyst's retreat from the patient's vantage point', by E. A. Schwaber; presented at Spring Meeting of the American Psychoanalytic Association.

SANDLER, J. (1976a). Countertransference and role-responsiveness. *Int. Rev. Psychoanal.*, 3: 43–47.

—— (1976b). Actualization and object relationships. *J. Philadelphia Assn. Psychoanal.*, 3: 59–69.

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SCHUKER, E. (REPORTER) (1990). Effects of theory on psychoanalytic technique and on the development of psychoanalytic process. *J. Amer. Psychoanal. Assn.*, 38: 221–233.

SCHWABER, E. A. (1983). Psychoanalytic listening and psychic reality. *Int. Rev. Psychoanal.*, 10: 379–392.

—— (ED.) (1985). *The Transference in Psychotherapy: Clinical Management*. New York: Int. Univ. Press.

—— (1986). Reconstruction and perceptual experience: further thoughts on analytic listening. *J. Amer. Psychoanal. Assn.*, 34: 911–932.

—— (1987). Models of the mind and data-gathering in clinical work. *Psychoanal. Inq.*, 7: 261–275.

—— (1990a). The psychoanalyst's methodological stance: some comments based on a response to Max Hernandez. *Int. J. Psychoanal.*, 71: 31–36.

—— (1990b). Interpretation and the therapeutic action of psychoanalysis. *Int. J. Psychoanal.*, 71: 229–240.

SCHWARTZ, H. J. (1987). Illness in the doctor: implications for the psychoanalytic process. *J. Amer. Psychoanal. Assn.*, 35: 657–692.

TYSON, R. L. (1986). Countertransference evolution in theory and practice. *J. Amer. Psychoanal. Assn.*, 34: 251–274.

VAN DAM, H. (1987). Countertransference during an analyst's brief illness. *J. Amer. Psychoanal. Assn.*, 35: 657–692.

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