

Countertransference, Sensory Images, and the Therapeutic Cure

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Countertransference is a phenomenon once felt, according to James Kern (1978), "to hold the same relationship to psychoanalytic work as wound infection holds to surgery" (p. 40). It was an indication of the therapist's inadequacy, something to be overcome, rooted out. As theory has evolved over the years, however, this view of countertransference has changed and it is now often seen as an important and creative tool in the therapeutic process.

This paper will present two related ideas dealing with the value of countertransference in psychoanalytic treatment. The first shows how the therapist's awareness and use of his or her own emotional responses leads to a better understanding of the patient, plus a change within the therapist, both of which contribute to that process within the patient that we call change, growth, cure.

The second presents ways the therapist can combine intellectual processes with awareness of sensory experiences -visual images, kinesthetic sensations, olfactory, and auditory cues to heighten awareness of countertransference, the unconscious process that can so easily elude the therapist and so quickly detract from effectiveness.

Both ideas connect the experiences of the therapist with that of the artist, particularly the performer, who uses the medium of self to create art. They relate to the thought that therapy (as Freud once said) is an art form and the therapeutic process is a creative process creative for the patient, for the therapist, and for the relationship between them. Countertransference has undergone a major re-evaluation since first discovered by Freud. Otto Kernberg (1965) describes two approaches to the idea. The first, the classical approach, similar to Freud's definition, sees countertransference as the "unconscious reaction of the therapist to the patient's transference," stemming primarily from neurotic conflicts of the analyst. Freud recommended that analysts learn to overcome their countertransference and view their patients with "the coolness of the surgeon," able to put human feelings aside in order to deal effectively with the problem at hand.

The second, the totalistic approach, sees countertransference as the "total emotional reaction of the analyst to the patient in the treatment situation." It includes not only reactions to the patient's transference indeed the "counter" transference where the therapist wonders, how does the patient want me to feel, but also the therapist's own transference to the patient based on early experiences of the therapist, plus the therapist's normal responses to the reality of the patient.

Kernberg feels that although the countertransference certainly must be resolved, a therapist in tune with his or her emotional responses will pick up cues about the patient otherwise missed. For example, I was yawning frequently in session a well-known signal of countertransference. Upon analysis of this and my tendency to

withdraw when confronted with aggression, I realized I had been working with A for over a year and not once had either of us commented on the fact that she is black and I am white. Shortly after my realization I remarked on it and the patient began speaking of the anger and distrust she has toward whites.

Kern (1978) speaks of countertransference as part of the therapist who is "a live human being with a live unconscious, with a valuable capacity for unconscious perceptivity (as well as everyday psychopathology)" (p. 41). This view of countertransference enables the analyst to deepen understanding of the patient's unconscious, Kern believes, as occurred both in his clinical examples and in the work I described with A. His thoughts relate to the idea of empathy described by Schaefer (1959) as the experience of sharing another's momentary psychological state, specifically "a sharing of another person's organization of thoughts, feelings, desires, defenses, controls, superego pressures, capacities, self-representations, representations of real and fantasied personal relationships": that ability to put ourselves in the skin of another person and to hear, smell, see, taste, and touch the roses and the weeds of another.

Empathy occurs through a regressive process, Schaefer points out. The therapist utilizes mechanisms of projection, introjection, and increased permeability of ego boundaries, remembering personal experiences of a similar nature, in consonance with reality testing, in order to achieve this state of unity. It is similar to Fleiss's concept of trial identifications, Schaefer suggests. I think we can also relate the process to that described by Ernst Kris, in *Psychoanalytic Explorations in Art*, of a spectator's involvement with the work of the artist, who recreates within the artist's process of creation.

To operate effectively, Schaefer states, empathy must combine with a cognitive component, so that the analyst knows it is vicarious, understands what has caused the situation to determine possible future events. The regression must be controlled and focused by the ego, similar, he says, to the artist's regression during the inspirational phase of creative production, which is focused on a work of art, and then later adds on or alternates with the conscious, critical, selective phase.

Schaefer presents two ways of viewing empathy. The first occurs in terms of affects experienced directly, in which the therapist, through means of the process described, undergoes a "re-creation of affect," so that he or she feels approximately as the patient does.

In addition to "re-creation" of affect, he says, empathy includes a "translation" of the therapist's reactive affects into stimulus patterns in the other person.

This second aspect of empathy, the translation of reactive patterns, was demonstrated earlier by Kern's thoughts of countertransference, (the therapist's use of his or her unconscious to understand the patient's unconscious) and by my example with A. It is also a part of Kernberg's definition of countertransference (Wondering: How do I feel? How do I want to feel? How does the patient want me to feel?) We see then that the same phenomenon the therapist's responses to the patient contains two different definitions: empathy or countertransference.

I do not wish to propose a specific definition for each variant of the occurrence. Rather, I wish to demonstrate an interconnection between the two, and to present

the concept that the therapist's reactions to the patient become both, potentially, a double-edged sword or the path to the end of the rainbow. In other words, the vital therapeutic response called empathy is easily shattered by countertransference, but that countertransference can become not only a disruption, but also a means to achieve an empathic unity between patient and therapist.

Schaefer talks of empathy as a creative act in personal relationships. Although there is a high degree of consciousness in both the artistic and empathic process, far more occurs in unconscious and preconscious elaboration. Expanding further on this, I think we can view empathy as a largely unconscious phenomenon, acting as a communication from unconscious to unconscious, from therapist to patient, that the therapist understands and supports the patient in their search for cure.

Nacht (1968), in speaking of countertransference, presents his thoughts that the unconscious relationship between patient and therapist is at times more important to the development of the cure than the conscious one. He reverses the emphasis I have made thus far on the therapist's comprehension of the inner workings of the patient. Nacht presents an idea, first formulated by Heinrich Racker (1966), of the patient's unconscious awareness of the analyst's psychological state. Like Racker, Nacht feels that the patient perceives clearly and intuitively the analyst's true and innermost attitudes, and the deepest moves of sensibilities, as precisely as the analyst perceives the patient's. Thus the quality of the countertransference response is important. If the patient perceives resistance, Racker and Nacht say, rather than a genuinely accepting attitude in the analyst, this can only increase the patient's.

Nacht also points out that scientists in the laboratory in the field of physics and chemistry report very subtle but constant modifications in themselves in response to their experimental work, so that upon completion of their project the experimenter is no longer quite the same person as before .

If this is so, Nacht suggests:

is it not tempting (and plausible) to believe that a man who acts upon the psyche of another undergoes in turn some imperceptible modifications within his own psyche? It seems to me quite inconceivable that, as a general rule, nothing can modify anything else without somehow being modified in turn. Did not the ancient Chinese Wise Men assert that everything was but "corresponding actions and reactions"! (1968, p. 316)

His ideas relate to comments by Kernberg and Kern regarding countertransference. Both authors discuss the fact that the necessary regression the analyst experiences in order to remain in empathic contact with the patient leaves the analyst unprotected and vulnerable to a reawakening of old conflicts. Kern's (1978) article presents a variety of clinical examples of his own countertransference responses, recognized through the use of visual images. All his examples, he points out, involved areas of conflict covered in analysis. However, Kern says, a therapist who calls on early psychic experiences in order to sample empathically the patient's struggle will touch on areas that have undergone major economic changes, but are never, of course, totally obliterated.

Kernberg's (1965) theoretical paper includes both a discussion of this issue and a description of a very difficult countertransference response occurring in therapists of all levels of skill and experience. The response has less to do with problems from the analyst's past, than from the patient's experience of hostile interpersonal relations occurring at a time the ego could not integrate them, and thus causing the patient to form in treatment a "premature intensive and chaotic transference." The therapist's countertransference reaction to this serves as a diagnostic sign that he or she is dealing with a severely regressed patient and the success of treatment will depend much on the analyst's ability to withstand stress and anxiety.

My work with M presented me with a countertransference situation similar to that Kernberg described. M is a borderline patient whose angry, rejecting mother resented all impingement. M saw me from the first session onward in the same way she described her mother: "rigid, unconcerned, interested only in her own needs." Her angry attacks on me became frequent and intense and I entered into a countertransference position Kernberg defines as a "complementary identification": the therapist's experience of empathic regression reactivates early aggressive identifications together with the mechanism of projective identification. The danger here is that the therapist can experience anxiety over impulses, a loss of ego boundaries in the interaction with the patient and the temptation to control the patient through identification of him or her with an object from the analyst's own past. Thus the analyst, unprotected through empathic regression, needing energy to defend against the patient's aggressive attack, will enter a countertransference position in which the therapist will experience the emotions that the patient projected into the transference object, while the patient experiences the emotions from the past. Thus I, the therapist, became the cold, distant mother as I withdrew emotionally from the barrage of abuse my patient heaped on me - similar to an early relationship with my sister - thus causing M to experience with me the same emotions she felt in childhood with her mother .

Kernberg says that the situation holds tremendous potential for harm to the patient should there be a reduplication of the early childhood trauma. Conversely, an analyst who retains part of his or her ego intact can use the experience to understand empathically how the patient felt under constant abuse from an angry mother. If the therapist can "snap out" of the countertransference hold, the situation offers great potential for therapeutic growth.

Kern, discussing similar ideas, speaks of the therapist's self analysis of old conflictual material reactivated in empathic regression. The result, offering restored empathy and greater understanding of the patient by both persons, indicates this effort is not simply a correction of an iatrogenic problem, but a valuable therapeutic process.

Both Kern and Kernberg discuss that source within the therapist that enables him or her to "snap out of the countertransference bind." Kernberg speaks of the therapist's concern for the patient; the concept of hope for the human race that a few persons, at least, can overcome their aggressive, destructive tendencies; the therapist's faith in himself or herself and technique.

Louis Berman (1949) describes the same countertransference problems as did Kernberg. He speaks of the dedication essential for the therapist to feel toward the patient in order for the therapist to understand the long and painful process of psychotherapy. He says, in describing the therapist's move from a difficult

countertransference position, that it is in "the patient's experience of the process through which the analyst under stress achieves realistic and well-integrated functioning that an important therapeutic factor is to be found."

This stress on the process within the therapist links up with Kern's appreciation of the therapist's remastery of old conflicts and leads to several ideas. First, it illustrates the concept of therapy as creative for the therapist, discussed earlier. (This benefit to the therapist relates to Schaefer's statement that the analyst's empathic behavior towards the patient enriches the therapist's ego; this altruistic attitude toward the patient may be based in part on the desire to recompense for this enrichment.) More importantly, the process of the therapist's remastery, the continuing cure, provides an important benefit to the patient. As Nacht said, the quality of the countertransference response is important, whether it contains a defensiveness or a genuine benevolence and an acceptance of one's positive and negative emotions. On that unconscious level in which the patient knows the therapist's resistances, knows intuitively exactly what the therapist is thinking, and is following the deepest moves of those sensibilities, the patient experiences the therapist's sense of mastery.

As I have had to cure myself with M, I pass the cure back to her. Just as the therapist can re-create the inner being of the patient, the patient can re-create that of the therapist. The therapist's ability for cure becomes for the patient a potent source of hope, or of despair.

Countertransference can play this role, however, only if recognized. Since so much of it operates on an unconscious level, the analyst must use all possible means to expand his or her consciousness of this process. Kern presents an extremely valuable discussion of the therapist's use of personal visual images during the therapeutic session. Initially he thought the very vivid images he saw during sessions demonstrated his empathy with patients. Upon examination, however, he found that whereas the "foreground" of his images related directly to his patients' productions and were part of his attempt "to dream along" with them, by creating pictures of their experiences, the "backdrop" of his scenes contained details that had no such relationship. They displayed instead his countertransference, not the obvious, noisy, squeaky wheels which could easily be oiled by prompt analysis, but stealthy low-profile reactions which one is inclined to ignore.

Visual images, which Freud used extensively in his early work and then abandoned for free association and verbalizations, are experiencing revived clinical interest. David Shapiro (1970) presents two schools of thought. One labels visual images as the expression of an impulse and the direct representation of an unconscious process. The other views them as compromise formations between impulse and defense, perceptual images that form when free association is blocked or transference resistances occur. They are conscious derivations of unconscious pressures within the patient.

Kern's images formed, he says, because of pressures within himself, the analyst, to retreat into sleep and avoid his awareness of countertransference, while simultaneously engaging his work ego to deal with the material. He stresses the value of the visual image in helping the therapist "sharpen his analytic instrument."

I have had a variety of visual images, some of which appear directly related to empathy.

A spoke of her great desire to change. She felt unable to do so, although she wanted greatly to break from her old way of doing things. I saw a large butterfly perched on her shoulder not yet ready to fly off. L spoke of his great agony. He felt everyone could see inside his mind and know all his problems. "My guts are hanging out, Susan," he kept saying. I saw his stomach open up and a large tangle of intestines spill onto the floor.

Some of my visual images combine with kinesthetic ones. A spoke of her intense fear of talking with a man. One night she spoke a sentence to a male. He replied and she spoke again - and suddenly the two were talking all night. I saw, and felt, a small box suddenly expanding.

Some of my visual images seemed like Kern's, that is, though I thought at first they denoted empathy, further examination indicated countertransference .

J spoke of conflictual feelings about women. He desired their life energy to complete him. He feared and hated their ability to reject him. Despite his desire to make love every night, he kept himself apart from women. I saw the Colgate Invisible Shield, complete with a kid hitting a baseball against it, and a man talking about toothpaste. At first I thought it was an image of J's shield against closeness with me (and the vagina with teeth). Then I recognized it also as my own distancing from him, in response both to my attraction to him, and my protection from anticipated, underlying rage.

L's face once appeared to me as Alfred E. Newman, the "What Me Worry?" man of Mad comics. I could not understand my representation of this man, who has been in treatment for 21 years, whose obsessive-compulsive tendencies and despair of ever getting well are an exact opposite of my image. Upon free associating to it, however, I realized it contained my anger towards the therapist named Al who had just transferred this patient to me and did not need to worry about the "mad" man who, I was just beginning to realize, had been misdiagnosed borderline with obsessive-compulsive features, rather than paranoid schizophrenic.

A final image: Shortly before M entered into a period of intense negative transference, she spoke rather intellectually of her anger towards her mother. Suddenly her youthful face changed into that of the devil complete with horns, goatee and furrowed brow. "Now what is this?" I thought. "My empathy with her anger toward her mother?" Upon reflection, I realized it also contained my countertransference, my image of her as the devil who would soon be directing her anger to me, the furrowing of my own brow with anger and anxiety.

As indicated, I have also experienced kinesthetic sensations relating to both empathy and countertransference. Some occurred with M whose only nurturing came from an aunt who held her in her arms .in a rocking chair at night. I noticed that during one phase of treatment I began sessions rocking gently back and forth in my seat as she responded with the same rhythm.

I have become aware of body experiences telling me that an idea that has been blocked is coming into consciousness in the form of a fluttering sensation in my chest

and abdomen. Such feelings have occurred when I am writing a paper and struggling to formulate my thoughts. Once in session, J made a statement that I sensed related to something, but due to countertransference blocks couldn't remember. Then I felt that sensation and saw a jelly-like amoeba float by. I threw out a fishing line, caught it with a hook, and remembered my connecting thought.

Jacobs (1973) speaks of these concepts. He notes that when the analyst listens well, and the analyst's unconscious vibrates with the patient, certain body responses will occur in turn with this: M in her rocking chair, for example, or L saying, "I need someone to hold my hand," and I realized I had lifted my hand slightly, in response.

Jacobs points to Fenichel's conception that identification with the patient is helped by taking over some of the object's movements to awaken psychic states. He points out that the infant's body has a keen awareness of somatic reactions and is, above all, a receiver of stimuli. The therapist, in a regressive, empathic state, has reawakened the sense of the use of the body as a prime conveyor of affect between mother and child. Thus the analyst not only has free access to memory, fantasy, and affects during empathic listening, but also a deeper sensitivity to somatic responses - a revival of sensitivity to body cues so important during infancy. This is useful not only in experiencing our empathy but in recognizing our countertransference, and various dynamics within our patients we might otherwise miss. He gives various clinical examples to show how the therapist's awareness of body movements within the patient, or him- or herself, lead to recognition of important unconscious processes. My yawning with A is an example.

Jacobs's use of body sensations is similar to that of Kern's visual images. I have noted that for myself, while visual images vary in frequency, body sensations are always present.

As Jacobs comments, I have noticed differences in the way I hold my body, modulate my voice with various patients -literally taking a different stance, setting a different tone. My body has been loose and relaxed with one patient, loose and listless with another, rigid and withdrawn with a third; cues I have examined in terms of countertransference.

Sometimes L, the paranoid schizophrenic patient, will comment my face looks funny and he doesn't think I understand how he is feeling. It is true that at that moment I had lost my concentration on him and my mind was wandering because he had triggered off a countertransference response in me. However, I had been unaware there was any movement at all in my facial muscles or change in my expression.

This incident relates to comments by Halpern and Lesser (1960) that the communion between mother and child is not based on mysterious, metapsychological means, but is probably the result of muscular, chemical cues from the mother. The child knows how the mother feels and smells and tastes, before the child can see how she looks. Probably, an angry, fearful mother tastes and smells differently than a good, self-confident one. It also relates to Jacobs's remarks that the body movements of the therapist can enhance or impede the flow of the patient's words, and that our patients know much of our inner psychological states because they note changes in the intensity of our breathing, small body movements, voice intonations, facial changes, and so forth.

Both statements are cues to the means our patients use to gain that intuitive knowledge of our inner processes.

Much of the body awareness suggested here relates to that which an actor learns in order to eliminate body tensions and bring himself or herself to a neutral point, so that the actor can take on the movements of the character, and thus enter that psyche. It is similar also to my experience taking singing lessons. As I learned to produce a pure sound, I learned to know what sounded good, not through my own perception of the sound alone but with the combined experience of hearing my own voice and feeling the various sensations in my diaphragm, throat, mouth, that meant I was singing well.

In a similar way I look for cues in my body sensations or visual images to tell me whether I am working well as a therapist. I have made mistakes in interpreting the meaning of my responses. Once I had a sense of a relaxed "high" knowing I had handled the session well. But on another occasion I had a light, airy feeling, and again thought it was a good session, only to recognize later I had misjudged the situation entirely. Other times I have felt a tightness in my throat, legs, mouth, and not recognized its meaning. Jacobs says the analyst may discover a personal pattern of body movements in response to specific emotions, as well as recognize those that pertain simply to fatigue or characteristic movements. I have found, so far, that the same sensations can signify anger, fear, competitiveness, rather than hold one particular meaning. As with James Kern's images, these sensations are a sign that something is happening and must be analyzed to determine their significance.

I have not experienced olfactory or auditory cues, as some therapists do. Jacobs says that each analyst has a differing awareness or sensitivity to various sensory channels depending on innate physiology, early childhood experiences, or personal style. However, whichever mode suits the individual best, sensory awareness enables the therapist to be in a fine tune with his or her unconscious and facilitates an awareness of countertransference - once viewed as a sign of weakness in a therapist, presented here as a valuable tool the mature therapist welcomes into the treatment situation. It provides cues to valuable information about the patient. It helps achieve empathic bonds. More important, the patient sees unconsciously the therapist's response to countertransference - whether rigid and avoiding or genuinely accepting of various emotional responses. The process by which the therapist handles personal conflicts suggests to the patient, on an unconscious level, an example of how he or she might similarly respond, and thus become a vital part of the therapeutic cure.

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