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 Sandler, J. (1976). Countertransference and Role-Responsiveness. *Int. R. Psycho-Anal.*, 3:43-47.

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## The International Review of Psycho-Analysis

 (1976). *International Review of Psycho-Analysis*, 3:43-47

### Countertransference and Role-Responsiveness

*Joseph Sandler* ⓘ

As we know, the term 'countertransference' has a great many meanings, just as the term 'transference' has. Freud first saw countertransference as referring to the analyst's blind spots which presented an obstacle to the analysis. From the beginning, countertransference was consistently seen by Freud 'as an obstruction to the freedom of the analyst's understanding of the patient.' In this context Freud regarded the analyst's mind as an 'instrument ... its effective functioning in the analytic situation being impeded by countertransference'. Countertransference in the analyst was equated with the resistance in the patient (**Sandler, Dare & Holder, 1973**).

As far as *transference* is concerned, it will be remembered that Freud saw it first as a hindrance, but later regarded it as an indispensable vehicle in regard to countertransference, but this inevitable step in the psychoanalytic literature when the countertransference analyst to understand the hidden meaning of material brought by the patient. The essential idea ... is that the analyst has elements of understanding and appreciation of the processes occurring in his patient, that these elements are not immediately conscious and that they can be discovered by the analyst if he monitors his own mental associations while listening to the patient' (**Sandler, Dare & Holder, 1973**). The first explicit statement of the *positive* value of countertransference was made by Paula Heimann (**1950**). Others have written on and developed the topic. However, the two papers by Paula Heimann (**1950**), (**1960**) have to be singled out as landmarks in the change of view of countertransference. She started by considering countertransference as referring to all the feelings which the analyst may experience towards his patient. Heimann remarks that the analyst has to be able to 'sustain' the feelings which are stirred up in him, as opposed to discharging them (as does the patient), in order to *subordinate* them to the analytic task in which he functions as the patient's mirror reflection'. She assumes 'that the analyst's unconscious understands that of his patient. This rapport on the deep level comes to the surface in the form of feelings which the analyst notices in response to his patient, in his "countertransference"' (**Heimann, 1950**).

I shall not mention the other important writings in this field, except to say that, of course, countertransference had been written about before Heimann's work and it had been pointed out that countertransference is a normal phenomenon. But what seems to have been stressed has been the differences between what one might call the 'appropriate' and 'useful' countertransference on the one hand and the 'dangerous' or 'undesirable' countertransference response on the other. Heimann's contribution was to show clearly that the reaction of the analyst may usefully be the first clue to what is going on in the patient.

 In *The Patient and the Analyst*

the literature

on transference was discussed in some detail (Sandler, Dare & Holder, 1973) and we concluded by commenting that, in our view,

*... transference need not be restricted to the illusory apperception of another person ..., but can be taken to include the unconscious (and often subtle) attempts to manipulate or to provoke situations with*

A contribution to a Symposium on 'The Importance of Countertransference in Current Psychoanalytic Practice', held at the English-speaking Conference of the British Psycho-Analytical Society, London, September 1974.

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*others which are a concealed repetition of earlier experiences and relationships. It has been pointed out previously that when such transference manipulations or provocations occur in ordinary life, the person towards whom they are directed may either show that he does not accept the role, or may, if he is unconsciously disposed in that direction, in fact accept it, and act accordingly. It is likely that such acceptance or rejection of a transference role is not based on a conscious awareness of what is happening, but rather on unconscious cues. Transference elements enter to a varying degree into all relationships, and these (e.g. choice of spouse or employer) are often determined by some characteristic of the other person who (consciously or unconsciously) represents some attribute of an important figure of the past.*

In our conclusions about transference we took the step of extending the notion of the patient's *projection* or *externalization* of some aspect of the past or of a figure of the past, on to the person of the analyst, to *all* his attempts to manipulate or to provoke situations with the analyst. I believe such 'manipulations' to be an important part of object relationships in general, and to enter in 'trial' form into the 'scanning' of objects in the process of object choice. In the transference, in many subtle ways, the patient attempts to prod the analyst into behaving in a particular way and unconsciously scans and adapts to his perception of the analyst's reaction. The analyst may be able to 'hold' his response to this 'prodding' in his consciousness as a reaction *of his own* which he perceives, and I would make the link between certain countertransference responses and transference via the behavioural (verbal and non-verbal) *interaction* between the patient and the analyst. Paula Heimann went as far as to point out that the analyst's response to the patient can be used as a basis for understanding the patient's material, often by something which he catches and holds in himself. I should like to try to take this a little further.

No one can doubt the value of the analyst's continuing analysis of his countertransference. We can, I believe, start by assuming that the understanding of countertransference *is* important. My own interest in the subject has, in recent years, run parallel with an interest in the psychoanalytic psychology of object relationships, and what I present in the following is based on the assumption that a relationship or, to say the least, an interaction, develops between the two parties to the analytic process. We are all aware of the special features of the analytic situation, with its capacity to induce the regressive revival of the past in the present, in a way which is usually entirely unconscious in or rationalized by the patient. On the other hand, we have the use made by the analyst of his special skills, including the employment by him of such capacities as that for free-floating attention, for self-analysis and for the maintenance of what Winnicott (1960) has called the 'professional attitude'. By free-floating attention I do not mean the 'clearing of the mind' of thoughts or memories, but the capacity to allow all sorts of thoughts, daydreams and associations to enter the analyst's consciousness while he is at the same time listening to and observing the patient.

I have mentioned the interaction between the patient and the analyst, and this is in large part (though, of course, not wholly) determined by what I shall refer to as the intrapsychic role-relationship which each party tries to impose on the other. One aspect of such a role-relationship can be appropriate to the task in hand, i.e. to the work of analysis. Certainly from the side of the *patient* we may see a whole variety of very specific role-relationships emerge. What

I want to emphasize is that the role-relationship of the patient in analysis at any particular time consists of a role in which he casts himself, and a *complementary* role in which he casts the analyst at that particular time. The patient's transference would thus represent an attempt by him to impose an interaction, an interrelationship (in the broadest sense of the word) between himself and the analyst. Nowadays many analysts must have the conviction (or at least the uneasy feeling) that the conceptualization of transference as the patient's libidinal or aggressive energetic cathexis of a past object being transferred to the image of the analyst in the present is woefully inadequate. The patient's unconscious wishes and mechanisms with which we are concerned in our work are expressed intrapsychically in (descriptively) unconscious images or fantasies, in which both self and object in interaction have come to be represented in particular roles. In a sense the patient, in the

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I want to use the term *actualization* in the dictionary sense of the word, not in the specific technical senses in which it has been used by certain writers. The *Oxford English Dictionary* defines *actualization* as 'a making actual; a realization in action or fact', and *actualize* as 'to make actual, to convert into an actual fact, to realize in action'.

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transference, attempts to *actualize* <sup>1</sup> *these in* a *disguised way*, within the framework and limits of the analytic situation. In doing so, he resists becoming aware of any infantile relationship which he might be attempting to impose. I want to underline, at this point, the difference between the manifest content of what the patient brings and the latent unconscious content (in particular the infantile role-relationships which he seeks to express or enact, as well as the defensive role-relationships which he may have constructed). If the patient keeps to the rules he will report rather than enact, and our clues, as analysts, to the unconscious inner role-relationship which the patient is trying to impose, come to us via our perceptions and the application of our analytic tools.

One could regard even the simplest instinctual wish as, from early in life, a wish to impose and to experience a *role-relationship* as a vehicle of instinctual gratification. However, what I have to say here applies not only to unconscious instinctual wishes, but *to the whole gamut of unconscious (including preconscious) wishes related to all sorts of needs, gratifications and defences.*

Parallel to the 'free-floating attention' of the analyst is what I should like to call his *free-floating responsiveness*. The analyst is, of course, not a machine in absolute self-control, only experiencing on the one hand, and delivering interpretations on the other, although much of the literature might seem to paint such a picture. Among many other things he talks, he greets the patient, he makes arrangements about practical matters, he may joke and, to some degree, allow his responses to depart from the classical psychoanalytic norm. My contention is that in the analyst's overt reactions to the patient as well as in his thoughts and feelings what can be called his 'role-responsiveness' shows itself, not only in his feelings but also in his attitudes and behaviour, as a crucial element in his 'useful' countertransference.

Let me give one or two examples to illustrate what I mean.

1. This patient, aged 35, had not had any previous analysis and had very little knowledge of the analytic process. He was referred to me because of extreme anxiety about making public presentations of his work, although he felt absolutely competent and at ease in private and informal discussions. He had had a very narrow education, was the son

of Eastern European immigrants, but because of his great financial and organizational skills had risen to a very high position in an extremely large financial organization. In the initial interview I found that he responded extremely well to trial interpretations, and I felt that work with him was going to be rewarding and a pleasure. During the first week or two of his analysis I found that I was talking very much more than I usually do. I should say that I am not an unduly silent analyst. After a little while I felt that something was making me anxious in regard to this patient, and some self-analytic reflexion on my part showed me that I was afraid that he would leave, that I was anxious to keep him, to lower his anxiety level so that he would stay in analysis and that I was talking more than usual in order to avoid the aggressive side of his ambivalent feelings. When I saw this, I felt relieved and reverted to my more usual analytic behaviour. However, I noticed at once the urge to talk during the session and became aware that the patient, by a slight inflexion of his voice, succeeded in ending every sentence with an interrogation, although he did not usually formulate a direct question. This gave me the opportunity to point out to him what he was doing (he was quite unaware of it, just as I had been unaware of it in him) and to show him how much he needed to have me reassure him by talking. He then recalled how he would feel extremely anxious as a child when his father returned home from work, and would compulsively engage his father in conversation, asking him many questions in order to be reassured that his father was not angry with him. His father had been a professional fighter, was very violent, and the patient was terrified of him but needed his father's admiration and love, to be the

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preferred child. (Later in the analysis we were, as one might expect, to see his fear of his own hostility to his father.) He told me that his father had the habit of not listening and not responding, and how frightening this was. The patient then realized that from early childhood onwards he had developed the trick of asking questions without directly asking them, and this had become part of his character, being intensified in situations where he feared disapproval and needed supplies of reassurance from authority figures.

The point I want to make here is that, apart from the 'ordinary' elements in his analytic work, the analyst will often respond overtly to the patient in a way which he feels indicates *only* his own (the analyst's) problems, his own blind spots, and he may successfully resort to self-analysis in order to discover the pathology behind his particular response or attitude to the patient. However, I want to suggest that very often the irrational response of the analyst, which his professional conscience leads him to see entirely as a blind spot of his own, may sometimes be usefully regarded as a compromise-formation between his own tendencies and *his reflexive acceptance of the role which the patient is forcing on him*.

Naturally, some analysts will be more susceptible to certain roles than others, and also the proportion of the contribution from the side of the patient and from the side of the analyst will vary greatly from one instance to another. And, of course, not all the irrational actions and reactions of the analyst are reflexions of the role into which he is manoeuvred by the patient. What I wanted to show in this example was simply how the patient, by a rather subtle element in his behaviour, evoked an overt response from the analyst which, at first sight, seemed to be *only* irrational countertransference. Let me say emphatically that I am absolutely opposed to the idea that all countertransference responses of the analyst are due to what the patient has imposed on him.

Let me give a further example.

2. This refers to a patient in her late twenties and a schoolteacher. She came to treatment because of social and sexual difficulties, and after some time it became clear that she was terrified of her penis-envy and of her hostility towards her mother, had multiple phobic anxieties and needed, mainly through intellectualization and organizational control of others, including her teaching, to 'structure' her world so that she always knew exactly 'where she was'. Her need to do this emerged in the transference, and after some three years of analytic work her psychopathology had become very

much clearer and she was much improved and happier. However, there was one strand of material which had remained rather obscure. From the beginning she had cried during each session, and I had routinely passed her the box of tissues whenever she began to cry. Now I did not know why I did this but, having begun the practice, I did not feel inclined to change it without some good reason. Without knowing why, I had not felt it appropriate to take up her failure to bring her own tissues or a handkerchief, although with other patients I would have done this. There were many determinants of her crying, including her mourning for the mother she wanted to kill off, for the father she felt she had to give up, and so on. It transpired that when she was about two years old and a second child, a brother, had been born, she felt that she had lost her mother's attention, and remembered that at about two and a half years of age she was relegated to playing on her own in the back-yard while her brother was being washed and changed. At this time she had also been sent to a kindergarten, and she had the memory of being very withdrawn and climbing into the rabbit hutch at the nursery school and cuddling a white rabbit. She then told me that she had later learned that after a short while at this school she was diagnosed as 'autistic' by the school psychologist, and was apparently very regressed and had uncontrollable rages and tantrums. By this point in her analysis we were able to get at the repetition in the present of her fear of soiling and disgracing herself, and her need to control her objects as she had to control her sphincters. However, there was clearly something which was an important unconscious fantasy for her and which had not been elicited. I had the feeling that we were somewhat 'stuck' in the analytic work. One day something rather unusual happened in the analysis. She had begun to cry silently but

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this time I failed to respond, and she suddenly began to upbraid me and criticize me for not passing her the tissues. She became quite panicky and began to accuse me of being callous and uncaring. I responded by saying that I did not know why I had not passed her the tissues at that particular point, but if she could go on talking perhaps we could both understand more about it. What emerged then was material which lent a great deal of specificity to something which we had not been able to crystallize previously. It became clear that her great need for control and for 'structures' in her life was based not on a fear of soiling herself, but rather on a fear that she would soil or wet herself *and*

*that there would not be*

*an adult around to clean her up*

This turned out to be the fear which dominated her life. It was a specific fantasy which seemed to have been elaborated during the late anal phase, under the impact of the mother's withdrawal from her because of the birth of the second child. The discovery and working through of this specific fantasy marked a crucial point in her analysis. I do not want to go into any more detail about her material, except to say that I think that I must have picked up unconscious cues from the patient which prompted me to behave in a certain way in her analysis, both to keep passing her the tissues and then to omit doing so. (It would be pure speculation to link the two and a half years of analysis with the age when her anxiety started.) I believe that this patient had forced me into a role, quite unconsciously on her part and on mine, a role corresponding to that of a parental introject, in which I enacted the part, first of the attentive mother and then suddenly that of the parent who did not clean her up. In the session I was not around to make sure that she was clean, just as she felt that, with the birth of her brother, her mother had not been around to clean her, being busy paying attention to the new baby.

Because the length of this presentation is limited I cannot go into this rich topic any further, and in conclusion I shall restrict myself to one or two points. I have suggested that the analyst has, within certain limits, a free-floating behavioural responsiveness in addition to his free-floating conscious attention.

Within the limits set by the analytical situation he will, unless he becomes aware of it, tend to comply with the role demanded of him, to integrate it into his mode of responding and relating to the patient. Normally, of course, he can catch this counter-response in himself, particularly if it appears to be in the direction of being inappropriate. However, he may only become aware of it through observing his own behaviour, responses and attitudes,

*after these have been*

*carried over into action.*

What I have been concerned with in this paper is the special case of the analyst regarding some aspect of his own behaviour as deriving

entirely from within himself when it could more usefully be seen as a *compromise* between his own tendencies or propensities and the role-relationship which the patient is unconsciously seeking to establish. I should add that I do not find the terms 'projection', 'externalization', 'projective identification' and 'putting parts of oneself into the analyst' sufficient to explain and to understand the processes of dynamic interaction which occur in the transference and countertransference. It seems that a complicated system of unconscious cues, both given and received, is involved. This is the same sort of process that occurs not only in the aspects of transference and countertransference discussed here but in normal object relationships and in the process of temporary or permanent object choice as well.

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