

When we think of transference and resistance we usually think of therapy patients. However, it has been pointed out by Freud and others that these processes can occur in or outside of the clinic. Many—if not most—people are caught up in the throes of transference and resistance, acting out a ritual of unreal behavior. They compulsively and impulsively live lives driven by unconscious forces and behave in ways that are destructive to themselves and others.

Therapists are not excepted from acting out transference and resistance feelings. When it occurs in the clinic, we call it countertransference and counterresistance. The problem is that patients come to us in order to get help in resolving their transference and resistance behavior, and when we respond with our own unresolved transference and resistance behavior, our ability to help them is greatly diminished. Our mission, so to speak, is to serve as models of realness.

We use the terms *countertransference* and *counterresistance* to represent all instances in which therapists act out feelings toward patients that are unresolved characterological or cultural conflicts or biases within themselves, whether or not induced by corresponding feelings in the patient. Our usage is an at-

tempt to transcend the varying current definitions of countertransference and counterresistance. We recognize that there are clinical thinkers who subdivide countertransference into two categories: objective countertransference, which is induced by the patient and which the therapist feels, without the temptation to act out on it; and subjective countertransference, which represents an irrational response to the patient rooted in the therapist's fixations. Others subdivide counterresistance in the same way. We think these are valid and useful categorizations.

Only in the first two or three years of a therapist's practice are errors usually technical and not primarily a result of countertransference and counterresistance. During this period therapists are trying to apply the theories acquired during their formal training. The most common technical errors have to do with learning how to select interventions that work best with the various patient types, making proper diagnostic formulations, extracting latent from manifest content, and maintaining therapeutic attitudes and boundaries that create an optimum environment for each patient's particular needs. For example, there are times—particularly in the beginning phase of treatment—when therapists set up a holding environment in which trust can be built; this is of particular importance for narcissistic patients. At other times—especially during the middle phase—a more active, confrontational stance may be required. These and similar technical procedures can usually be mastered early in the therapist's career. Eventually, the focus of supervision shifts almost exclusively to issues of countertransference and counterresistance.

Unfortunately, when countertransference and counterresistance are operating, the therapist is at first not likely to be aware of them, since they are linked to unconscious drives. A major clue for the therapist is the rather intense feelings—either erotic or aggressive—that are experienced at such times. A therapist “possessed” by countertransference feelings may find himself irresistably attracted to a patient, have murderous feelings, or feel inordinately protective. When in the throes of counter-

resistance, therapists may find themselves reluctant to discuss certain subjects or unreceptive to certain kinds of feelings expressed by the patient, such as sexual or angry or loving feelings. Therapists under the sway of counterresistance may be silent, try to change the subject, or attempt to use interpretations to thwart a resisted idea or feeling. For example, a patient may express anger at the therapist who is resistant to anger; such a therapist may be hasty in interpreting that this anger does not belong to the therapist, but should be directed at the patient's parents. In cutting the patient off with this interpretation, the therapist does not give the patient the chance to ventilate feelings with the therapist in order to find out where the feelings belong, nor does the therapist in this situation give the patient the chance to discern the difference between the real relationship with the therapist and the transference relationship. Again, all of this is usually unconscious, and the therapist might employ rationalizations to justify such behavior. Only when a therapist pays close attention to the intense feelings aroused by a particular patient can there be awareness of the countertransference and counterresistance factors involved.

Even when therapists are conscious of experiencing countertransference or counterresistance feelings, they may attempt to deny them. Some therapists do not think they have the right to feel such emotions (particularly sexual or aggressive emotions); others are afraid of being swept away by them. In such cases, therapists are likely to defend themselves against the feelings by hiding behind their "therapeutic neutrality," offering inappropriate interventions in order to immediately push away the feelings, or expressing the feelings indulgently without regard for the patient's welfare. In any case, the therapist's reluctance to experience these feelings in an analytically appropriate manner then serves to reinforce the patient's already strong resistance to accepting and verbalizing his own transference feelings.

On the other hand, when utilized properly, countertransference and counterresistance feelings and urges can be a well of

information from which to draw. The therapist who can tolerate the feelings being induced by the patient, who can clearly identify them, analyze them, and control them, has at his disposal, as Donald Winnicott points out, a "hands-on" experience of his love and hate in reaction to the actual personality and behavior of the patient, based on objective observation. When a therapist is on top of his countertransference and counterresistance feelings, he is running, rather than being run by, the therapy. He can use such feelings to creatively plan his working relationship with the patient in such a way as to ensure the most advantageous kind of outcome.