Medical Research Archives

European Society of Medicine

OPEN ACCESS

Published: January 31, 2024

Citation: Lewis O, 2024. Countertransference Teaching: The Challenge of Going Beyond Literature, Novel Approach, Medical Research Archives, [online] 12(1). https://doi.org/10.18103/mra.v12i1.4926

DOI
https://doi.org/10.18103/mra.v12i1.4926

ISSN: 2375-1924

RESEARCH ARTICLE

Countertransference Teaching: The Challenge of Going Beyond Literature, Novel Approach

Owen Lewis, M.D.

Clinical Professor of Psychiatry and Clinical Professor of Psychiatry in Medical Humanities and Ethics, Columbia University Vagelos College of Physicians and Surgeons; Adjunct Professor of Psychiatry, Albert Einstein College of Medicine.

(Recipient of the 2023 Guernsey International Poetry Prize, the 2023 Rumi Prize for Poetry, and the 2016 International Hippocrates Prize for Poetry and Medicine.)

Email: owlewismd@gmail.com

ABSTRACT

While countertransference in its various definitions has become central to psychoanalytic theory and practice, and countertransference is acknowledged as central to most care-giving practices, the opportunities to know and explore countertransference in most mental health training programs is limited. Applying approaches of Narrative Medicine didactics, this paper proposes and demonstrates how the group study of clinically relevant literature (novels and short stories) under guided discussion can lead to the identification and exploration of countertransference reactions. The scope of this paper is to report on a single class taught for ten years using literature to teach adolescent development with the finding that it became a forum to explore various countertransference arising in psychotherapies with adolescents, an approach that can be broadly applied.

Introduction: The Problem

A significant discovery of Freud's theory of mind was the centrality of transference. It was generally agreed that for real psychic change to occur, a specific transference must emerge in the analytic relationship. Freud viewed countertransference solely as interference.[10] It was subsequent writers who elaborated the therapeutic role of countertransference. This concept at first was used specifically in the analytic setting, and was defined not as a general emotional response to a patient but as a specific response to "transference neurosis." In a seminal paper by Tyson and Tyson [26], additional transference-like phenomenon was elaborated. These included: habitual modes of relating, transference predominantly of current relationships, transference predominantly of past experiences as well as transference neurosis proper.

Expanding the concept of transference in this way necessarily expanded the concept of countertransference. Marshall[18] describes various sources of countertransference in the following paradigmatic transactions:
patient/conscious acting on therapist/conscious
patient/unconscious acting on therapist conscious
patient/conscious on therapist/unconscious
patient/unconscious acting on therapist/unconscious

In short, he maps out who is doing what to whom in the therapeutic relationship and further elaborates various ways therapists can be aware of these reactions and use them therapeutically. While countertransference gained acceptance over time in classic psychoanalytic thinking, the interpersonal approach (Sullivan's concept of therapist as participant observer) always formulated therapy in terms of the relationship between patient and analyst, each carrying his own subjectivity.[24] Contemporary psychoanalytic thinking now approaches these phenomena through the concept of intersubjectivity.[2] As Gabbard [12] notes, countertransference is now often viewed as a "jointly created phenomenon" that "has moved to the heart of psychodynamic technique."

Although contemporary psychoanalysis continues to value and expand the place of countertransference, the reality for most mental health trainees is that there are limited opportunities to explore and understand countertransference in its many iterations and uses. In contemporary psychotherapies such as Cognitive Behavioral Therapy (CBT) or Dialectical Behavioral Therapy (DBT), the thrust of the therapy is amelioration of symptoms regardless of the etiology of those symptoms. Transferences, positive or negative, are situations to be managed, not analyzed, and thus these interactions typically do not provoke reflection and self-examination on the part of the therapist. Even in training programs that include training in insight-oriented psychotherapy, only rarely do cases progress to the development of an interpretable therapeutic transference, and hence the opportunities for most trainees to discuss this experience with a supervisor are limited. The same limitations apply when it comes to supervisory discussions of more general feelings about patients and the situations in which they involve therapists.

Where, when, and how to use one's feelings as therapist are decision-points mostly reserved for advanced trainees. It is that much more perplexing for trainees who have not had any psychotherapy of their own, and for them the realm of self-interrogation remains underdeveloped. It is a paradox that despite these considerations it is still generally accepted that a therapist's feelings and reactions to a patient are paramount to successful psychotherapy and that serious errors ensue when this is overlooked. The overall practice of medicine as well as general mental health practice are dominated by electronically generated symptom check lists and decision-making menus limited to evidence-based protocols. The inclusion of Narrative Medicine components into the curriculae of medical schools occurred in part to address the diminished opportunities for self-reflection in medical training and practice and to introduce self-reflection as a clinically meaningful core skill.[4]

Importantly, the Narrative Medicine influence potentially opens up the use of psychoanalytic concepts of countertransference to all health care providers. It is, after all, axiomatic that knowledge and awareness of self are necessary tools for anyone who would deliver care of any kind. While only the most comprehensive Narrative Medicine curriculae can hope to create a sufficient ethos of self-awareness among providers, intensive clinical teaching in this area is rarely available for trainees in any discipline. So it is that within medical practice as a whole, including the specific culture of contemporary mental health care, professionals must often find their own way.

Method:

This paper is to be considered a "case report" which raises questions about accepted practice, and here the "case" is a "class." Approximately forty students have taken this course over a ten year period. I periodically kept a log of student experiences,

reactions, and reflections, and from these drew my conclusions which are reported here.

There is an extensive literature on teaching countertransference arising in both adolescent and adult psychotherapies in the setting of either an ongoing case seminar or in individual supervision.[17, 21, 25] From my literature search there are no reports of using literature to teach countertransference. The problem remains that most non- psychoanalytic mental health trainees have limited training in recognizing, understanding, and using their countertransference reactions[3, 22] and alternatives need to be found.

A Proposed Solution

The approaches of a Narrative Medicine curricula were applied to the development of a course for post-graduate mental health trainees. The implications of this approach for a wider application of this approach will be explored.

For almost ten years, I have been teaching a course to Child and Adolescent Psychiatry Residents at the Albert Einstein College of Medicine entitled "Adolescent Development Through Literature". The course extends over ten months and this duration is important. Books discussed usually include: *The Member of the Wedding*, Carson McCullers; *Anne Frank: Diary of a Young Girl,* Anne Frank; *Bonjour Tristesse,* Françoise Sagan; *Manchild in the Promised Land,* Claude Brown; and selected stories of Junot Diaz, Lydia Conklin, and John Updike. Also included are selections from Jonathan Evison's *Lawn Boy,* Torrey Peter's *Detransition, Baby,* Andre Aciman's *Call Me by Your Name,* and Delmore Schwartz's *In Dreams Begin Responsibility*. The course was designed to provide vivid descriptions of characters and their inner worlds by authors often close in age to those characters. These characters set the stage for a discussion of psychoanalytic and epidemiological studies of adolescence. Various theories of adolescent development emerge and becomes manifestly clear. To cite a few of these writings and their relevance to adolescent developmental theory: the stages of adolescence[1, 14, 15, 16]; pathological reactions to adolescence[10, 13]; and the norms of adolescent *sturm and drang*.[19]

As noted, the course was organized to illustrate aspects of adolescent development, what emerged over the years was that trainees' personal reactions to both adolescent characters and the general adolescent situation would be revealed. The more fully I understood this, the better able I became in tactfully posing questions that would lead to open discussions of the residents' personal histories. Just as countertransference emerges narrowly with time-limited cases, and more fully with longer-term cases, so will students allow themselves to divulge personal reactions to these characters and adolescent situations in a class of longer duration where trust both in the instructor and class process can develop.

Many adolescent situations are portrayed in these stories and novels that are familiar to the clinician. Clinicians are able to allow themselves a freedom of responsiveness to "characters" that they do not permit themselves in the clinical situation. It is more acceptable to be enraged by a character than by a patient, to "love" a character, to "hate" that character's parents. In the clinical role, the trainee must be "professional," and this is often at the exclusion of personal reactions to the patient or the situation. For trainees trying to be take in all the data, to create a comfortable rapport, and to deliver care, their personal feelings are last on the list of what must be considered. In a literature course, on the other hand, with instructor encouragement, many feelings can and do arise in the students, often to the surprise of the students themselves. These become particularly highlighted when the question is asked, "What would you do with this character if she brought this dilemma to your office?"

Among the earliest potential manifestations of countertransference reactions in treating adolescents are a general resistance to adolescence itself and the opposite, an idealization of adolescence. It comes as quite a shock to most approximately 30-year-old trainees that their 15-year-old patients see them as closer in age to their 70-year-old teacher than to themselves. At 30, in Western cultures, many individuals have not fully settled into their adult selves and are inclined to see themselves as flush with adolescent passion. So while they may be readily touched by the conflicts of adolescence, at the same time they are somewhat terrified by the risk-taking, the impulsivity, and the contradictions of their patients. This ambivalence must be elicited and explored for them to be able to fully access their adolescent selves in the service of real empathy for their struggling patients.

Frankie Adams, the almost thirteen-year-old protagonist of *The Member of the Wedding* [20], has been feeling quite dejected at the novel's opening, caught in growth spurt, spurned by slightly older neighborhood friends, and restlessly keen to belong. She is irritable, sullen, and critical. On the occasion of a visit by her older brother and his fiancé who announce that they'll be getting married

the following week, Frankie becomes obsessed with this marriage, in effect falls in love with the marriage, and almost delusionally believes that the new couple will take her along into their new life. In this belief that she is becoming joined to them, all depression disappears and Frankie feels elevated, in love with life again, and invincible.

Students are sometimes charmed by her extreme moods, and sometimes irritated by them. One student remarked that with a similarly aged patient, she never knew whether the sullen or exuberant version of her patient would appear. Through the character of Frankie, this trainee was "allowed" to feel irritated herself for the first time. It is reminiscent of Anna Freud's comment[10], "Analyzing an adolescent is like running after a freight train." While one accepts the vicissitudes of adolescent moods and identifications, finding an appropriate therapeutic stance requires a recognition of how, as a therapist, one actually feels in these quixotic and evanescent moments.

In Frankie's exuberant mood, she encounters a soldier on leave who invites her to have a drink. She meets up with him, sips a beer, then accepts an invitation to see his room. As a class, on one occasion we are reading this passage aloud, the tension mounts as the soldier attempts to get her to bed, and a student exclaimed that she didn't know what was going to happen to her? She further wondered how her father could let her wander around. The student expressed both alarm at the character's dangerous exploration and the need for parent control—fear of the impulses and a parental identification. The class was then prompted by the instructor, "Can you recall a time in your adolescence when you took a big risk?" And so a more immediate recall of adolescence begins. How much risk can the therapist tolerate? Will the therapist enter the patient's experience or identify with the parents and attempt to protect the child? Both identifications are necessary, but access to these as therapeutic positions needs to occur in response to the patient, not in response to re-awakened conflicts in the therapist. The ambivalent identification with both parent and child is a universal countertransference reaction, but also may contain case-specific content.

As a former student expressed it, "I found myself drawn to Frankie Addams. She reminded me of the awkward transitions of pre-adolescence, especially as a young woman waiting to enter a world that is enticing in its opportunities and scary in its complexity. I notice with my early adolescent patients, especially with girls, my instinct is to provide reassurance along with the lines of 'It gets better.' Sitting with Frankie Addams's discomfort allowed me to acknowledge how disquieting the early adolescent experience was, and its reverberations even as an adult working with early adolescents." (Rollhaus, 2023)

In *The Diary of Anne Frank* [9], we are introduced to the Frank family living in hiding with another family. Anne, in the first throes of adolescence, has somewhat idealized her father and denigrates her mother and older sister. "I feel myself drifting further away from Mother and Margot (p.87)," and "They're so sentimental together. I'd rather be sentimental on my own. Daddy's the only one who understands" (p.96). Finally she declares, "I finally told Daddy that I love him more than I do Mother." (p.142) These are not uncommon statements for an adolescent to make, and the types of statements a therapist might hear. Again, to my question about how a therapist might respond to her, a resident got quite angry chastising me for only pursuing individual therapy, and not family therapy. Grist for the mill. And what should happen in family therapy? Not family therapy, the resident replied, contradicting herself—parent counselling. And what should happen in parent counselling? The mother should be told to act stronger with her daughter and the father should support her. The intensity of the responses were noted. After a discussion of the pro's and con's of individual versus family therapy, the resident revealed that she is in the midst of a custody battle for her own six-year-old daughter who at the time was in a phase of idealizing the resident's ex-husband. Without judgement, the class explored their sympathies for all members of the family, and the resident was able to understand just how emotionally challenging in a personal way an adolescent patient might be.

Adolescent sexuality can be another trigger for emotional reactions. In "The Black Winter of New England" [5], three female friends regularly meet in a cemetery. They are discussing an upcoming party, with its attendant peer pressure. One says, " 'Chill out, everybody . . . Let's do a practice sex and then go home.' " One holds the other down while another inserts her fingers into the third and, at the same time, they objectively discuss who has more pubic hair and what to do with it. In another novel, "Lawn Boy" [8], two male friends masturbate while watching heterosexual pornography, one of whom feels some excitement for the other. While some students take such passages in stride, many express both surprise and curiosity about the experimentation, the casualness of the encounters, and seeming fluidity of object choice. These reactions can be considered generic countertransference reactions, and do not pertain to individual issues. If trainees were to wait

for patients to describe such activity, they might wait years. Such passages provide an opportunity for trainees to sensitize themselves to the gamut of adolescent sexual activity and perhaps remember their adolescent years. Beyond that, however, specific issues may arise in individuals which require some processing. In response to these passages, for instance, one trainee "confessed" that he had to skip over these passages, that he felt like a voyeur, and came from a background where pornography was strictly banned. When asked what he might do in a clinical situation, he claimed that it had never come up. This allowed the class to examine the way in which covert anxieties may impeded the clinical process.

A final example will highlight the way cultural differences can be examined and feelings about different cultures can be discussed despite an assumption of universal acceptance. Junot Diaz[6, 7] stories are set in Dominican neighborhoods in New York City and in rural Santo Domingo. "Ysrael" portrays an act of unusual cruelty as two teenage brothers hunt down a facially disfigured teenager they've heard about and unmask his disfigurement. "The Pura Principle" describes those brothers' family a few years later when one of the brothers, Raffa, has cancer, avoids in a macho way his treatments, takes on a girlfriend, and acts with utter entitlement, stealing what he wants from his mother and brother.

The characters and families described resonate with the residents' experience with patients from neighborhoods near the hospital. As we were reading the passage which describes the unmasking of Ysrael, one resident blurted out that she hates "this culture" and what it does to children. The statement alarmed both the trainee and the class, but we pursued the discussion. The residents cited cases of child abuse and neglect, frustrations in working with families, and parental abandonment. These are impoverished families with limited means to help their children and generations of deprivation. There is no question that these residents acted in completely professional ways with their patients, yet how did such feelings affect, if not thwart, their attempts to effectively engage with their patients from these backgrounds? The class discussion moved in the direction of how to find empathy for victims and perpetrators of abuse in the context of cultural and economic marginalization, and the realization these unexpressed negative transferential feelings impeded empathy.

Conclusion

Four examples were given which highlight different aspects of countertransference. The first, the general resistance to empathically entering earlier, more impulse-driven stages of experience; the second, specific conflicts around parental versus child identifications; the third, around adolescent sexuality; and the fourth around adolescent sadism and the stresses of family and childhood experiences of abuse and trauma.

Returning to Marshal's schema of the sources (conscious or unconscious, patient- or therapist-derived) of countertransference, it cannot be said that a character per se has either a conscious or an unconscious mind. Characters are created with the author's conscious craft that, in the most effecting literatures, taps the author's unconscious, and so it may be said that characters, like patients, act through conscious and unconscious means. Reactions in the therapist may be conscious or unconscious. The beauty of using literary characters to elicit these reactions is that the character does not need to be taken care of. The focus is all on the therapist's reactions. These may be indulged, expanded, and explored without immediate clinical consequences. One does not have to be concerned about how the therapeutic relationship is maintained in the throes of a negative or excessively positive reaction. The character remains contently on the page, beyond clinical exigencies. The class format allows the therapist to sort out, in Tyson and Tyson's categories, whether the therapist's reactions are expectable types of reactions (for instance, the ups and downs of adolescent moods) or are reactions arising from specific projections of the patient. In either case, literature and its discussions provide a safe and nonjudgmental, almost "therapeutic", environment where therapists, particularly trainees, can encounter their own feelings, process those feelings and reflect on those feelings without immediate clinical consequence.

As noted, a class of sufficiently long duration is necessary to give participants time to trust the class process. The class described here was organized to teach approaches to adolescent development through literature. That it had this task allowed the class to focus on the task, not exclusively on their reactions, though over the course of the class, those reactions become more and more central. As a model of teaching countertransference, it is an approach that has wide applicability outside of adolescent psychotherapy. Similar courses could be arranged in the literatures of addiction, trauma, psychosis, or geriatrics, to note a few.

What is learned from Narrative Medicine is that patients' and caregivers' voices, or representations of them, must be heard, and heard in way that invites caregivers' personal and ongoing reflections and connections. In this format, the once specific term, countertransference, has applicability across all caregiving professions.

Acknowledgement

Special thanks to Dr. Robert Catenaccio with whom I first taught this course; to Dr. Audrey Walker, Chief of the Division of Child and Adolescent Psychiatry at the Albert Einstein College of Medicine who has allowed me to develop and expand this course; and to Dr. Robert Abrams for his careful edits and critical review.

Owen Lewis, M.D., Clinical Professor of Psychiatry and Clinical Professor of Psychiatry in Medical Humanities and Ethics, Columbia Vagelos College of Physicians & Surgeons; Adjunct Professor of Psychiatry, Albert Einstein College of Medicine. Dr. Lewis is a co-author of *Psychotherapies with Children* (A.P. Press) as well as four collections of poetry. He is the recent winner of the Guernsey International Poetry Prize and the Rumi Prize for Poetry, as well as a past winner of the International Hippocrates Prize for Poetry and Medicine.

References:

1. Blos P. Intensive psychotherapy in relation to the various phases of the adolescent period, in Esman An (ed) *The Psychoaalytic Treatment of Adolescents,* International University Press, New York. 1983: 71-88.
2. Bohleber W. The concept of intersubjectivity in psychoanalysis: taking critical stock. *Int J of Psychoanalysis*. 2013; 94: 799-823.
3. Caracci G. Teaching countertransference to residents: a survey. *J Am Ac of Psychoanalysis and Dynamic Psychiatry*. 1997; 25(3): 617-621.
4. Charon R. Williams P, eds. Special Theme Issue: The humanities and medical education. *Acad Med*. 1995; 70:758-813.
5. Conklin L. The black winter of new England. *Rainbow, Rainbow*, Catapult, New York. 2022: 31-56.
6. Diaz J. Ysrael. *Drown*. Riverhead Books, New York 1996: 3-20.
7. Diaz J. The pura principle. *This Is How You Lose Her*. Riverhead Books, New York 2012: 91-118.
8. Evison J. *Lawn Boy*. Algonquin Books, Chapel Hill, 2018.
9. Frank A. *The Diary of a Young Girl* (definitive edition). Anchor Books, New York, 1996.
10. Freud A. Adolescence. *The Psychoanalytic Study of the Child*. 1958; 13: 255-278.
11. Freud S. The future prospects of psychoanalytic therapy (1910). *Standard Edition*. 1955; IX, Hogarth Press, London: 144-145, 1955.
12. Gabbard G. The role of countertransference in contemporary psychiatric treatment. *World Psychiatry*. 2020; 19(2): 243-2442.
13. Laufer M, Laufer ME. *Adolescence and Developmental Breakdown*. 1984, Yale University Press, New Haven.
14. Lewis O. The paranoid-schizoid position and pathologic regression in early adolescence. *J Am Acad Psychoanalysis*. 1987; 15(4): 503-519.
15. Lewis O. The depressive position and middle adolescence: developmental and therapeutic considerations. *J Am Acad Psychoanalysis*. 1989; 17(3): 377-395.
16. Lewis O. Adolescence, social development, and psychotherapy. *Am J of Psychotherapy*. 1993; 47(3): 332-333.
17. Liegner E. Focused countertransference exploration in classroom teaching of modern psychoanalytic candidates," *Clinical Social Work Journal* 2007; 35(4): 277-286.
18. Marshall R. Countertransference in the psychotherapy of children and adolescents. *Contemporary Psychoanalysis*. 1979; 15(3): 595-629.
19. Offer D, Ostrov E, Howard K. Adolescence: what is normal? *Am J Dis Child*. 1989; 146(6): 731-736.
20. McCullers C. *The Member of the Wedding*. Houghton Mifflin Company, New York, 1946.
21. Nadler R. Utilizing reflected countertransference: applying the reflection process as a teaching tool in supervision. *Canadian Psychiatric Association Journal* 1976; 21(3): 145-150.
22. Price T, Roberts C, Fatollahi J, Gandhi B. Teaching professionalisms and countertransference to psychiatric residents. *Psychiatric Annals*. 2016; 46(5): 298-302.
23. Rollhaus E, private communication; 2023.
24. Spiegel R. Development of Sullivan's theory of participant observer. *Contemporary Psychoanalysis*. 1977; 13(3): 372-376.
25. Tarnopolsky A. Teaching countertransference. *Canadian Journal of Psychoanalysis*. 1995; (3(2): 293-313.
26. Tyson R, Tyson P. The concept of transference in child psychoanalysis. *Journal of the American Academy of Child Psychiatry*. 1986; 25(1): 30-39.