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Letters to the Editor

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Letters to the Editor

DR. GARCIA RESPONDS TO DR. KIM'S ARTICLE ON COUNTERTRANSFERENCE IN INPATIENT PSYCHIATRY

To the Editor:

Dr. Kim's article on countertransference in inpatient psychiatry (1) is welcome for its emphasis on the need for the psychiatrist to maintain ceaseless vigilance over his own mental life as he engages in the treatment of patients. Indeed, one could persuasively argue for the necessity of concurrent psychoanalysis as the only adequate safeguard against countertransference (which I use in the classical sense), especially given the powerful and frequently psychotic transference reactions of hospitalized patients which are so apt to awaken new conflicts or resuscitate "resolved" ones in the therapist.

Although he wrote very little about countertransference, Freud clearly and definitively regarded it as an obstacle to treatment, an interference, and he characterized it as a force seeking to drag the analyst down from the analytic level which must be overcome (2,3,4). Dr. Kim's view that Freud was ambivalent about countertransference is mistaken, as a closer examination of the paper he cites to support his conclusion shows.

In "Recommendations to Physicians Practicing Psycho-Analysis"* (5) Freud's advice that analysts adopt the "surgical" attitude of concentrating "on the single aim of performing the operation as skilfully as possible" (p. 115) was given as a caution to the potentially dangerous attitude of therapeutic ambition which so easily subverts treatment. This constitutes a methodological recommendation which does *not* conflict with Freud's description of the means by which an analyst reconstructs the patient's unconscious, namely, by using his own unconscious as a receptive instrument (pp. 115-116).

Thus the "apparent contradiction" Dr. Kim perceives does not really exist. In fact, to underscore the lack of ambiguity that characterizes Freud's view of countertransference, one may cite a passage from the very section in which he discusses the matter of the analyst's receptive unconscious (5):

He [the analyst] may not tolerate any resistances in himself which hold back from his consciousness what has been perceived by his unconscious; otherwise he would introduce into the analysis a new species of selection and distortion which would be far more detrimental than that resulting from concentration of conscious attention (p. 116).

Without explicitly using the term "countertransference" it nevertheless seems sufficiently clear that these unresolved repressions that constitute blind spots of analytic perception (5) are the seeds from which countertransference interferences sprout. Hence the necessity for "psycho-analytic purification" and continued self-analysis of the therapist.

*Curiously Dr. Kim uses the earlier English title in his cited reference, not the title which appears in the Standard Edition (5).

On the other hand, the totalistic conceptualization of countertransference, in which every thought, image, idea, fantasy, feeling or somatic rumbling occurring in work with a patient has come to be considered a countertransference response, lacks specificity and cogency. Restricting the definition of countertransference to Freud's by no means implies that the therapist's mental processes have been shorn of diagnostic or therapeutic utility. It must be remembered that they are ultimately productions of the therapist's psyche, regardless of how strong the transferential pull of the patient may be, and that it is the therapist's duty to maintain awareness of when they may threaten to interfere with treatment. For example, to fantasize a sexual encounter with a patient is not an example of countertransference, while assuredly an actual sexual encounter would be. However, the fantasy itself may provide an important clue to the nature of the patient's transference, although one must bear in mind that the complexity of mental events and the opacity of manifest fantasy content resist facile generalization. One gets the impression from the "totalists" that an erotic or hostile fantasy about a patient necessarily reflects erotic or hostile feelings experienced by the patient—a gross oversimplification.

I would like now to turn my attention to the case report (Case #3) which Dr. Kim used to illustrate projective identification.

Was the resident really experiencing the patient's own projected ambivalence? And was it necessary for him to think that he was experiencing her ambivalence before he could empathically confront the patient? I venture to answer both questions in the negative, and to set forth a more parsimonious explanation that does not require invocation of projective identification.

In response to the patient's intense ambivalence to her intended separation from her husband—so intense as to throw her into an acute suicidal crisis—the resident became confused and unsure of the direction of treatment. The feelings of confusion and uncertainty seem to me to be legitimate, non-countertransferential responses per se. However, if I read the last sentence of the anecdote correctly, it sounds as if the resident somehow understood the purpose of the hospitalization as being the patient's separation, and that he "bought into it" as evidenced by his hopelessness about "the likelihood of the separation lasting more than a few weeks" (p. 38). In the context of the patient's impulses to commit suicide, the prevention of which would first and foremost be the hospitalization's purpose, the resident's response is curious and suggestive of countertransferential elements that would interfere with appropriate treatment.

One may say overall that the resident was unsure about which alternative would be the lesser of two evils, that is, (1) encouraging separation, with its attendant risks of the patient's being overwhelmed by the loss of a relationship to the extent that she might choose death over isolation, or (2) facilitating the patient's return to her alcoholic, and presumably erratic, abusive and dangerous husband. Indecision about which of the alternatives to support is understandable and need not be seen as the result of a projection from the patient, least of all a projection with which the patient in turn identified.

Simple recognition of the patient's ambivalence over separation and the empathic response in treatment were possible without having to assume projected ambivalence: the ambivalence was encapsulated in the patient's presentation of suicidality at the thought of leaving her husband, accompanied by a manifest desire to leave him.

No doubt there are deeper complexities which Dr. Kim was unable to address, and there are wider areas of countertransference to be explored, e.g., when to regard therapeutic errors in inexperienced trainees, be they wild interpretations or faulty discharge-planning, as countertransferential phenomena or not.

I find it useful to regard transference as a force that seeks to convert the therapist into an inhabitant of the world of pathogenic images which the patient is continually seeking to impose on reality. The surest sign of countertransference occurs when one finds oneself accepting the extravagant praise or vicious vilification of patients as reliable referents to oneself, instead of acknowledging their sources in the patient's past. In other words, *the denial of transference is the essence of countertransference*.

The above comments are intended not to detract from Dr. Kim's useful article, but to offer an elaboration of the crucial issues of treatment which he has brought into focus.

Emanuel E. Garcia, M.D.
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S.E. = Standard Edition of the Complete Psychological Works of Sigmund Freud. London: Hogarth Press.

DR. PINCUS AND DR. SPURLOCK ANNOUNCE THE NEW APA MINORITY RESEARCH TRAINING IN PSYCHIATRY PROGRAM

To the Editor:

The American Psychiatric Association (APA) is pleased to announce the funding of the Minority Research Training in Psychiatry Program by the National Institute of Mental Health (NIMH). This program will sponsor training of minority medical students, psychiatric residents, and fellows who are interested in research by providing advice, placement assistance, stipends, travel, and other expenses.

For further information about the Minority Research Training in Psychiatry Program, call or write Harold Alan Pincus, M.D. or Jeanne Spurlock, M.D. at the American Psychiatric Association, 1400 K Street, N.W., Washington, D.C. 20005; telephone (202) 682-6238; or FAX 202-682-6114.

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ON THE DEVELOPMENT OF ANTIPSYCHOTICS

To the Editor:

I appreciate your invitation to comment on "Mechanisms and Therapeutic Implications of Neuroleptic Atypicality," the article by Dr. Javitt published in Volume 7, 1989, of the Jefferson Journal of Psychiatry. The article is informative and timely. The author crafts a grand context into which the imminent clinical use of clozapine in the United States can be appreciated. His integration of preclinical models, receptor pharmacology, electrophysiology, and exposition of thorny clinical issues surrounding the treatment of the schizophrenic patient, is a 'must read' for those who are interested in the mechanisms of action and development of neuroleptic agents.

Dr. Javitt's scant reference to work of the immediate past, for whatever reason, should probably not be taken as evidence that there has been a dulling of the cutting edge of neuropharmacology and drug development. Yet most would admit that the leviathan cost of thoroughly developing and testing new drugs promotes an adherence to a vernacular neuropharmacology—one that is often associated with well-established (if not shop-worn) basic preclinical models, and the prevailing pathopharmacological depiction of the target disease. Although new approaches are taking hold, it must be noted that truly novel antipsychotic agents have eluded psychopharmacologists thus far.

Readers who were drawn to Dr. Javitt's article, and who have also had training in clinical or basic research, might do well to actively consider a research career within the pharmaceutical industry. It is within this industry that much of the progress in new therapies for psychiatric illnesses has been made, and where the "Enterprise" of psychopharmacology research is to explore (beyond science-fiction) "... new worlds . . . and to boldly go where no man has gone before."

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DR. KIM RESPONDS TO DR. GARCIA'S COMMENTS

To the Editor:

I appreciate Dr. Garcia's elaborating on the essential consistency of Freud's attitude toward countertransference (Vol. 7, No. 1.) As I stated, the "contradiction" is only apparent. Subsequent reflection and clinical experience since the writing of my paper has modified my views on the two contrasting models of countertransference. I have found it helpful to consider a "generalized" versus a "pathological" form of countertransference. One might even go so far as to use Dr. Garcia's nomenclature by referring to the first type as "nonspecific" countertransference. This by no means deprives the concept of clinical cogency; as Dr. Garcia points out, such fantasies can be quite useful in understanding the patient's transference. Both are internal responses resulting from neurotic conflict within the therapist, but in the latter case the therapist is unable to make use of this material. Dr. Garcia is quite correct that the ultimate source of all countertransference is the therapist's own psyche; it can be tempting to blame the patient for every powerful and frightening affect. I am sorry if I appeared to suggest that every emotional response within the therapist necessarily mirrors the patient's own intrapsychic milieu.

Regarding Case #3, the patient's stated purpose for hospitalization was to work through her overwhelming feelings; she already had (according to her) decided to leave her husband. The resident, taking this decision at face value, encountered much resistance when he supported this side of her ambivalence. While his confusion and indecision might have been independent of countertransference, the feelings of anger, frustration and hopelessness he experienced were clearly countertransferential. When first confronted with her own ambivalence the patient became angry, hostile, and vehemently denied any indecision. In the end she had no explanation for her abrupt reversal. Kernberg's description of projective identification seems to fit this clinical vignette:

The subject projects intolerable intrapsychic experiences onto an object, maintains empathy with what he projects, tries to control the object in a continuing effort to defend against the intolerable experience, and, unconsciously, in actual interaction with the object, leads the object to experience what has been projected onto him (1).

Dr. Garcia's explanation that this illustrates a natural ambivalence on the resident's part between two equally unsatisfactory choices has merit, and such is the case in many instances. Nevertheless, it appears to me that another process was also at work, one which greatly complicated the therapeutic work and experience of both patient and therapist.

Again, my thanks to Dr. Garcia for his helpful comments and for providing me with the opportunity to clarify certain ambiguities in my paper.

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