15

# Countertransference in the Treatment of Addictive Disorders

*ALAN M. JAFFE AND*
*KAREN L. JAFFE*

Countertransference is a clinical phenomenon in which the therapist's ability to listen and empathize is compromised and distorted by his own unresolved psychological issues. These issues make it difficult for the therapist to differentiate himself from the patient's own cognitive and emotional experience, and thereby he feels and responds subjectively to the patient. If the therapist is unaware of his countertransference, it can result in an empathic failure with the patient. Countertransference is most likely to occur when therapists are dealing with patients whose problems evoke a personal response in the therapist, a particularly common occurrence in the treatment of the addictions, since virtually everyone's life is touched in some way by an addicted individual.

## DEFINITION OF CONCEPT

Kernberg (1975) summarizes the two schools of thought regarding the phenomenon of countertransference. The classical approach, as proposed by Freud (1910), Fliess (1953), Gitelson (1952), and Reich (1960), defines countertransference as the unconscious emotional reaction of the therapist to the patient's transference. In this model, countertransference is looked upon as a disturbing factor, interfering with the objective and presumed neutral position to be taken by the therapist. It adversely colors the therapist's perception.

The totalistic definition is the alternate school, giving broader meaning to the concept. In this model, countertransference is viewed as the "total emotional reaction of the psychoanalyst to the patient in the treatment situation" (Kernberg, 1965, p. 50). Representatives of this approach view countertransference

material as a valuable tool for understanding the patient. The basic assumption is that the therapist's unconscious understands the unconscious of his patient and that the emotional response of the therapist is frequently closer to the psychological state of the patient than the therapist's conscious judgment of the same.

Little (1951) highlights the importance of understanding the countertransference reaction because it can have a decisive effect on the patient's ability to reexperience childhood situations. The therapist's tendency to repeat the behavior of the patient's parents, a manifestation of countertransference, can interrupt the important opportunity to reexperience childhood emotions with a more objective and support-giving individual.

Nadelson (1977) stresses the significance of countertransference as a means of extending one's understanding of the patient that yields further information of the patient's experience of the world. This position is further discussed by Spitz (1956), who views countertransference as a "necessary prerequisite of analysis" (p. 257). Once accepting this presumption, Spitz outlines the steps involved in making the best use of countertransference material. In the first step, the therapist becomes aware in himself of the manifestations of his unconscious responses. Step 2 involves the therapist's inferring the underlying unconscious processes in himself. In step 3, the therapist possesses sufficient freedom to perform a transient trial identification with those processes in the patient that elicited his or her countertransference response. Spitz's manner of handling countertransference presupposes that the therapist is conscious of the countertransference issues involved in a given patient-therapist interaction. Marshall's (1979) configuration of possible countertransference issues suggests that what he labels "Type III countertransference" (p. 417), where the difficulties are not seen by the therapist and the patient is essentially in control of treatment, needs to become "Type IV countertransference" in which "the patient is primarily responsible for inducing thoughts and feelings (but no action) in the therapist which are fully within the therapist's awareness" (p. 417). Marshall suggests that the transition of Type III into the more usable Type IV countertransference occurs through the process of supervision and peer discussion.

Spotnitz (1979, p. 331) uses the term *subjective countertransference* to describe "atypical feeling responses which are attributable to insufficiently analyzed adjustment patterns in the therapist and are usually rooted in distortions created by memory process." Winnicot (1960) discusses a related distortion: "objective countertransference" (p. 70), which involves those therapist feelings provoked by the patient's transference feelings and attitudes. Marshall (1979) differentiates subjective and objective countertransference by stating that in the former, the countertransference feelings are "induced primarily by the internal promptings of the therapist" (p. 415), while in the latter the countertransference is generally induced by external factors, the patient.

Often in the treatment of addicted patients, anger emerges toward the therapist due to the perception that he is taking away something (the addictive symptom) that the patient perceives as critical to his existence. This is a product of the therapist-patient relationship. When experiencing anger toward the therapist, it is as if the addicted patient loses all memory of any other positive experience (Shapiro, 1978). The therapist who desires to help is frustrated not just by nonappreciation on the patient's part but is met with the patient's anger (Jaffe, 1980). Not considering the patient's behavior in a theoretical context might leave the therapist feeling worthless, restless, and bored.



## OVERIDENTIFICATION

Overidentification is a countertransference problem that probably occurs with greater frequency in the treatment of addictive disorders than in any other mental health subspecialty. The reason is that there are a great number of paraprofessional counselors and therapists who are providing services to people with similar problems. For example, virtually all alcoholism and substance abuse programs have staff members who are themselves recovering alcoholics and substance abusers. Programs dealing with eating disorders, especially overeating, utilize personnel who have learned to control their eating behavior. When describing the desirability of having female therapists work with the anorexic patients, Wooley (1991) states, "The female therapist will at times experience an identification with the patient's emptiness, her dearth of energy" (p. 260). This type of treatment we refer to as *identification counseling*. This self-identification counseling approach, considered by many to be an important component of any treatment program, can be an effective therapy supplement as long as the counselor understands his ego boundaries or where his experience ends and the patient's begins.

A common countertransference pitfall for those providing help to others from the self-identifying perspective is to see the patient's experience as paralleling his own, to the point of perceiving it inaccurately (Schafer, 1959). Research has shown that recovering alcoholic counselors perceive a greater dependency on alcohol in patients than do their nonrecovering professional counterparts (Skuja, 1981). This form of overidentification causes the patient to experience the therapist as presumptuous. The therapist presumes to understand the patient better than the patient does himself because the therapist identifies with some common element. The patient also tends to perceive the therapist as being authoritarian because he, at least unconsciously, adopts the position that "my way worked for me, so it must work for you!" This approach denies the patient the uniqueness of his own phenomenology and deprives him of the accurate empathic mirroring necessary for a healthy adjustment. Problems of undifferentiation of this kind can contaminate the therapeutic process.

It is also common for overidentification countertransference to occur in a therapist for whom there is little similarity (not even a common addiction) with the patient. The prerequisite condition for overidentification, after all, is not

the actual commonality between therapist and patient but the perceived commonality. A therapist who overidentifies will mistakenly respond to the properties of his own unresolved transference (Spotnitz, 1979) that appear to take form in the person of his patient. The unconscious need for the therapist to find an external object (the patient) to work through his own unresolved conflicts (Jaffe, 1977) often provokes a severe negativistic reaction in the patient, which is further misunderstood and likely to be misbandled by the therapist.

## PROJECTIVE IDENTIFICATION-COUNTERTRANSFERENCE

Projective identification describes a two-step process in which an individual projects his own conflicts, needs, anxieties, or problems onto another person (object). Second, the individual from whom the projection originates attributes with the projected material to the recipient. What differentiates projective identification from overidentification is the degree to which the therapist engages in projective countertransference with the patient. An example is the substance abuse counselor who has a tendency to overevaluate substance abuse because he is a recovering substance abuser and has an unconscious need to work through unresolved issues. We have all witnessed some overzealous recovering addiction counselors who view counseling as an obligation rather than a clinical subspecialty. These individuals exhibit a tendency to project their own addiction onto those who do not quite exhibit the symptoms; then they go about attempting to help the patient with a problem he or she does not (exactly) have.

An example of projective identification in everyday life is the stereotypic aging widow who lives in an apartment with her lap dog. She treats the dog with very special care so that its nails are always manicured, coat perfectly groomed, eats only ground beef, and never gets dirty. One might ask whether the dog requires such pampering, and of course the answer is "no"; the dog would be just as happy to roll around in dirt and eat bones off the ground. The dog does not wish to be pampered; the *woman* does. She projects her desire to be pampered onto the dog, attends to the projected need, and then identifies with the dog while it is being pampered. This represents projective identification in which an individual attempts indirectly to take care of his own needs by taking care of them in an external object.

## DEALING WITH THE PATIENT'S PROJECTIVE IDENTIFICATION

The patient also engages in projective identification, with the therapist serving as the object. "When the patient employs projective identification with the therapist, the therapist may confuse the source and feel the feelings which well up inside as her own" (Clark, 1989, p. 312). Subjecting these feelings to intrapsychic scrutiny provides a paradigm of reinternalization and "genuine psychological growth" (Ogden, 1979, p. 362).



## PROJECTIVE COUNTERIDENTIFICATION

The process thus far described does not allow for the revelation of therapist's own personality and history. Of course, the individual's therapist has his own areas of strength and weakness, which can inhibit and possibly prohibit the therapist's ability to provide a corrective experience for the patient. Grinberg (1962) and Langs (1979) address the potential problems that can arise, as well as suggestions for avoiding such difficulties. Grinberg states that the patient's excessive use of projective identification "gives rise to a specific reaction in the analyst, who is unconsciously and passively 'led' to play the sort of role the patient hands over to him" (1962, p. 436). He labels this phenomenon *projective counteridentification*. This is a specific type of countertransference reaction that Grinberg differentiates from countertransference reactions resulting from the analyst's own emotional attitudes, or on his neurotic remnants, reactivated by his patient's conflicts.

In projective counteridentification, the therapist is a passive object of the patient's projections and interjections. Here the therapist's response stems from his own unresolved issues, reactivated by the patient's conflicts. However, the emotional response may be quite separate from the therapist's own emotions and appear primarily as a reaction to the patient's projections upon the therapist. Once this form of countertransference has occurred, the therapist tends to respond to the patient's projected material as if it is meant in a very real and personal way about the therapist. Occasionally the therapist becomes so personally enmeshed in this process that he may have the feeling of no longer being himself and seems to become the object the patient wanted him to be. "A feeling of bewilderment is often experienced by the therapist who may resort to rationalize the discomfort. Additional supervision and personal therapy can aid the therapist in regaining a sense of cohesive identity" (Jaffe, 1977).

## REPOSITORY PROJECTION

*Repository projection* is a term we developed to describe countertransference phenomenon, which is similar to pure projective identification in function but not in form. The similarity lies in the unconscious projection of the therapist's issues onto the patient, the difference lies in the formal properties of the therapist's response namely, the lack of identification with the patient. So although the therapist is engaging in projection of his own material (usually negative), the patient becomes a repository for these negative issues.

A typical example is the substance abuse therapist who projects his problems with control onto the patient, seeing himself as being excessively controlling although in reality he is not. The therapist, projecting his own compensatory

need for extreme control, in effect deposits this need onto the person of the patient and then responds to it as if it entirely belongs to the patient. This type of countertransference is found in therapists who tend to adopt a defensive style that involves externalization of negative aspects of the self.

The defense, which is predominant in this countertransference process, is projection, just as it is in projective identification and overidentification. Ogden (1979) considers the repository phenomenon as a type of projective identification: "as a group of fantasies and accompanying object relations having to do with the ridding of the self of unwanted aspects of the self: the depositing of those unwanted 'parts' in another person; and finally, with the 'recovery' of a modified version of what was extruded" (p. 357).

As a result, these countertransference phenomena present treatment problems and impasses, with notable boundary problems between patient and therapist. These problems with boundaries arouse additional transferences in the patient, particularly for those with dysfunctional families (as described by Schlessinger & Horberg, 1988) and especially those who were intrusive and failed to respect the patient's boundaries earlier in life. This causes a recapitulation of these earlier unresolved autonomy issues, which have a tendency to compromise the therapeutic alliance to a dysfunctional level, paralleling the early family experience. Since the therapist is himself in the dark as to the cause of this pathological interaction, he is of no help to himself or the patient to correct it without supervision. It is amazing that the therapeutic relationship does not collapse as a result.

## EMPATHIC RESISTANCE

The countertransference phenomenon demonstrating the most primitive defense on the part of the therapist is what we call *emphatic resistance*. This represents a defensive posture in the therapist in which denial is prepotent. Because denial is of the lowest level of ego defense, it causes the greatest amount of distortion in the therapist's perception and therefore the treatment itself.

Empathic resistance is seen when the therapist is totally unable to understand elements of the patient's psychic functioning because he defended against seeing it internally. For some time it has been observed in medical practitioners who unknowingly work with addicted patients. Physicians unable to identify addictive problems in themselves are unable to diagnose them accurately in their patients. This has led to the gallows humor frequently told among addiction specialists, as follows: Question: "What is the definition of an alcoholic?" Answer: "A patient who drinks more than his doctor!" Anyone working in the addictions field has witnessed countless times that physicians misdiagnose patients because of their own denial defense. A great number of addictions are caused by physicians who prescribe (poorly monitored) tranquilizers to patients who are attempting to manage anxiety that the physician (due to his own defense structure) is unable to comprehend except in the most simplistic way. Blocked from understanding the true nature of their own anxiety, they unwittingly lead their patients down the road to addiction. At the very least, physicians have a tendency to diagnose or misdiagnose addictive problems according to their own internal predispositions (Horberg, Heslein & Jaffe, 1983).



Overweight therapists who are unable to see the eating addiction in their patients and cigarette-smoking clinicians who avoid dealing with this problem in the people they see are the common examples of empathic resistance.

## PROBLEMS OF IDENTITY

### Distortions of Diminution

This type of countertransference is similar in form to empathic resistance, but the defensive constellation that causes it is higher level. While the primary defense operating in empathic resistance is denial, problems of identification derive from the defenses of rationalization and intellectualization. Therefore, we find it necessary to develop a separate category that more accurately differentiates the defensive properties of the countertransference response. An example of a distortion of diminution is the therapist who is uncomfortable on a conscious level with the intensity of his own anger. This appears in his style of treatment by his unconscious tendency to reduce the expression of his patient's anger by the therapist's affable and somewhat jovial manner. Not only is he unconsciously manipulating the patient to limit his affective expression, but he also is unable to appreciate fully the seriousness of the patient's problem with anger when it is expressed. There is a tendency to rationalize it away or deal with the anger on a purely intellectual level. This leads the patient into believing (at an unconscious level) that his anger is unacceptable, and there ensues an unconscious collusion with the therapist to conceal or reduce the existence of any affect with which he cannot comfortably identify.

The therapist's problems identifying with certain aspects of the patient's emotional life are relayed rapidly as an unconscious communication early in the treatment and interfere with the therapy. If what occurs in the therapist is an overreliance on his cognitions, "this prevents a necessary degree of regression. Such is the case in naive, pedantic, 'psychological' explanations of patients in which generalizations substitute for concrete reference, imagery, and affective tone" (Schafer, 1959, p. 347).

Distortions of diminution are often seen in therapists (not trained in the addictions) who are uncomfortable with their own issues involving compulsivity and hence find it difficult to understand how anyone can really become addicted. They are the therapists who advise their addicted patients, "Just don't drink so much," or "Just watch how much you eat and promise yourself you won't vomit anymore." It is easy to see how this countertransference problem

J. Masterson and R. Klein (eds.), *Psychotherapy of the Disorders of the Self* (pp. 308–27). New York: Brunner/Mazel.

Fliess, R. (1953). Countertransference and counteridentification. *Journal of the American Psychoanalytic Association, 1,* 268–84.

Freud, S. (1957). The future prospects of psychoanalytic therapy (1910). *Standard Edition, 11,* 139–51. London: Hogarth Press.

Giovacchini, P. L. (1975). *Psychoanalysis of character disorders.* New York: Jason Aronson.

Gitelson, M. (1952). The emotional position of analyst in psycho-analytic situation. *International Journal of Psycho-Analysis, 33,* 1010.

Grinberg, L. (1962). On a specific aspect of countertransference due to the patient's projective identification. *International Journal of Psychoanalysis, 43,* 436–40.

Horberg, L., Heslein, R. & Jaffe, A. (1983). *Reluctance to diagnose alcoholism in middle-class patients.* Paper presented at the American Psychological Association, Anaheim, Calif.

Jaffe, A. (1977). *The role of personal therapy in clinical training.* Paper presented at the Fall Conference of the Illinois Psychological Association.

Jaffe A. (1981). The negative therapeutic reaction. *Psychotherapy: Theory, Research and Practice, 3,* 313–19.

Jaffe, K. (1980). *Countertransference in the treatment of a borderline adolescent.* Ph.D. dissertation, Illinois School of Professional Psychology.

Kernberg, O. (1965). Notes on countertransference. *International Journal of Psychoanalysis, 13,* 38–55.

Kernberg, O. (1975). *Borderline conditions and pathological narcissism.* New York: Jason Aronson.

Langs, R. (1979). The international dimension of countertransference. In L. Epstein and A. Feiner (eds.), *Countertransference.* New York: Jason Aronson.

Little, M. (1951). Countertransference and the patient's response to it. *International Journal of the Psychoanalysis, 32,* 32–40.

Marshall, R. J. (1979). Countertransference with children and adolescents. In L. Epstein and A. Feiner (eds.), *Countertransference.* New York: Jason Aronson.

Nadelson, T. (1977). Borderline rage and the therapist's response. *American Journal of Psychiatry, 7,* 134.

Ogden, T. (1979). On projective identification. *Journal of Psychoanalysis, 60,* 357–73.

Reich, A. (1960). Further remarks on counter-transference. *International Journal of Psychoanalysis, 41,* 389–95.

Schafer, R. (1959). Generative empathy in the treatment situation. *Psychoanalytic Quarterly, 28,* 342–73.

Schlessinger, S. & Horberg, L. (1988). *Taking charge.* New York: Simon and Schuster.

Shapiro, E. R. (1978). The psychodynamics and developmental psychology of the borderline patient: A review of the literature. *American Journal of Psychiatry, 135,* 1305–15.

Skuja, A. (1981). Treatment attitudes of recovered alcoholic counselors and nonalcoholic counselors. *Alcohol Dependency, 8,* 61–68.

Spitz, R. (1956). Countertransference: Comments on its varying role in the analytic situation. *Journal of the American Psychoanalytic Association, 4,* 256–65.

Spotnitz, H. (1979). Narcissistic countertransference. In L. Epstein and A. Feiner (eds.), *Countertransference.* New York: Jason Aronson.



Tansey, M. J. & Burke, W. F. (1989). *Understanding countertransference.* Hillsdale, N. J.: Analytic Press.

Winnicot, D. W. (1966). Report on panel: Problems of transference in child analysis. *Journal of the American Psychoanalytic Association, 14,* 528–37.

Wooley, S. (1991). Use of countertransference in the treatment of eating disorders: A gender perspective. In C. Johnson (ed.), *Psychodynamic treatment of anorexia nervosa and bulimia* (pp. 245–94). New York: Guilford Press.

compromises the effectiveness of treatment because serious problems are not adequately addressed.

A study conducted at Northwestern University Medical School demonstrated that physicians are less likely to diagnose alcoholism in middle- to upper-class patients admitted for some other medical problem (Horberg, Heslein & Jaffe, 1983). It can be inferred that this statistically significant phenomenon occurs as a result of the physician's difficulty understanding that compulsive behavior can occur in the social class to which he belongs. Proof is found in the increased frequency with which alcoholism is diagnosed among low-class patients. The defense of rationalization is apparent when reading the admission notes written from members of differing social classes. The middle-to upper-class patient's note might read as follows: "A 41 y/o white, married, executive reported drinking 1 quart of vodka per day was admitted for pancreatitis," whereas a lower-class patient's note would say, "A 37 y/o white, single, unemployed alcoholic was admitted for pancreatitis." The distortion in perception is understood as a problem of physician identification with lower-class patients.

Social class appears to be an important factor in the diagnosis and management of alcoholic inpatients treated in medical and psychiatric facilities. Physicians are slower to refer and less likely to diagnose alcoholism when the patient is upper or middle class even when the alcoholic pathology is extreme, the patient openly discusses his drinking when asked, and the patient is treated for conditions resulting directly from alcoholism such as alcoholic hepatitis (Horberg, Heslein & Jaffe, 1983).

### Distortions of Magnitude

Distortions of magnitude, or acting out, can be described as the countertransference response in which the therapist causes an increase in the patient's impulsivity or an increase of symptomatic behavior. The therapist's relationship to potential acting out will depend in part on the therapist's need for the patient to demonstrate (magnify) his impulse expression (the opposite of diminution). Brown (1978) suggests that the therapist's need to magnify impulsivity in the patient will certainly interfere with treatment:

> Some therapists unconsciously encourage and vicariously enjoy their patients' acting out. . . . On the other hand, the therapist's being overly anxious about the patient's acting out is reacted to by the patient, who then unconsciously gratifies his sadism as well in the acting out, and gets a spurious sense of power and independence through it. (p. 466)

Part of what can make the acting-out patient annoying for the therapist, and lead to countertransference difficulties, is the implicit message in the acting out: the patient does not wish to take into account any significant etiological factors arising from within himself (Giovacchini, 1975). This can be experienced by the therapist as a negation of his value (Jaffe, 1981). The therapist's



permitting of excessive abuse would be what Kernberg (1965) calls "masochistic submission" to the patient's aggression. He explains this submission as a large part of the therapist's work, which involves the experience of giving something good and receiving something bad in return. The aspect that frustrates the analyst-therapist is his inability to correct such a situation through "the usual means of dealing with reality. It is as if in his relationship with that particular patient, the analyst would have to lose confidence in the force that could neutralize aggression; this in turn reactivates the analyst's masochism" (Kernberg, 1975, p. 61). And based on Kernberg's position, a younger and less experienced therapist is particularly vulnerable to this form of submission.

One problem confronted by the young or inexperienced addiction therapists involves striking a satisfactory compromise between natural spontaneous interaction and maintaining a professional posture. It appears that professional posture is a standard that grows out of the young therapist's experience as a supervisee and out of his own fantasy about how a therapist is expected to behave. The supervisor offers his perceptions of what is taking place in the case and how it might be handled. The student can use his supervisor's perceptions as well as his own. It appears that most young therapists go through a period of discovery when they realize that their self-styled image of a professional psychotherapist has little hope of surviving against the real moment-to-moment interaction with a patient. This is particularly true when considering the intensity so characteristic of work with addicted patients.

When dealing with addicted patients, it is important for the therapist to consider the phenomenon of countertransference in the context of the family. The presence of the family, specifically the parents and other siblings, increases the number of variables that the therapist must attend to. Rather than examining one's thoughts and feelings in relation to just one individual, the therapist must examine those thoughts and feelings evoked by issues that arise from the interaction of family members. The family, with a unique set of problems, has the potential to elicit a wide range of reactions on the part of the therapist. The intense affect, which typically becomes manifest in the interactions of dysfunctional families, requires the therapist to be particularly sensitive to how he is responding to such a powerful onslaught of psychopathology. This is necessary in order to avoid acting out the conflicts of the family. It is important for the therapist to gain insight into himself and to adjust to the particular family's set of contingencies in order for the treatment to proceed. This can be applied to the expanded therapeutic encounter which includes the individuals making up the family of the addicted patient.

## REFERENCES

Brown, S. (1978). Acting out in adolescence: Genesis and some treatment implications. In *Adolescent psychiatry: Developmental and clinical studies* (vol. 6). New York: Jason Aronson.

Clark, K. (1989). Countertransference to transference acting out of hopelessness. In