

Transference and Countertransference in Pastoral Care, Counseling and Supervision

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INTRODUCTION

Transference and counter-transference are psychodynamic phenomena with an uneasy history. People often seek pastoral care and pastoral counseling for painful problems in living that confound them—problems they act out through reciprocal transferences toward each other. It is commonplace for our patients and trainees to be largely or completely unaware of these dynamics because of their unconscious origin and function. As transference and counter-transference dynamics occur and are then interpreted, a typical first reaction of patients, trainees and supervisors in training is to feel self-conscious, embarrassed, and ashamed. Making oneself vulnerable at deep emotional levels elicits the terror of being exposed and shamed to the core of one's self. This fear regularly leads people to avoid situations in which a therapist or supervisor might interpret material

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Reflective Practice: Formation and Supervision in Ministry

ISSN 2325-2847 (print)* ISSN 2325-2855 (online)

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outside of the person's awareness, and these dynamics are at the root of resistance to intra-psycho self-understanding. The clinical fact of flight from the intra-psycho reality of our unconscious processes is the driving force of all our defenses.

Moreover, clinical pastoral supervisors are not exempt from these dynamics, so as they emerge in our supervisory work we are also dealing with our own countertransference. Therapists and supervisors have been more comfortable talking about these phenomena as they occur in the behavior of our patients and supervisees than in ourselves. In this article I trace not only the development of our understanding of transference and countertransference but also the role our aversion plays in our failure to apply knowledge of transference and countertransference to ourselves and our own clinical work. I conclude this article with some thoughts about how to mitigate our clinical and supervisory failures through a better understanding of resistance, both latent and manifest, in transference and countertransference. New directions are also suggested for curricula in the training of persons in pastoral care, counseling and supervision.

My focus is restricted to the phenomena of transference and countertransference and to an exploration of how these phenomena emerge in three clinical cases. The first case is literally the first case: Dr. Josef Breuer's famous treatment of Anna O. The second and third cases come from my own work in pastoral care and pastoral counseling. A discussion that follows is focused on some key aspects of transference and countertransference that surface in these cases. I conclude with suggestions about the implications of this discussion for the supervisory training of chaplains and pastoral counselors.

CASE ONE

In 1882, Josef Breuer fled from his treatment of Anna O. in the face of her erotic transference toward him, which reached a climax in her symptoms of an hysterical pregnancy through which she delusionally regarded him as the father of her wished-for baby.¹ Equally unnerving to Breuer were his fear of his own erotic feelings, and the fact that he understood neither the upwelling of Anna O's sexual dynamics nor his own.²

Today, we need to remind ourselves that the concepts of transference and countertransference did not yet exist in 1882; they were subsequently

described by Freud to articulate and explain what had occurred to Breuer and his abandoned patient.³ In fact, psychoanalysis itself did not yet exist at that point, but in the following years Freud's understandings of transference and countertransference developed through his encounters with these phenomena in his own cases as he worked to develop the theory and technique of psychoanalysis. It took eleven years before Breuer's case report of his work with Anna O. was published, along with several of Freud's earliest cases, in their book *Studies on Hysteria*.⁴

Freud's understanding of transference (as well as his psychoanalytic theory in general) grew and developed over time as an outcome of his clinical experience. In the early years when he and Breuer utilized the "cathartic method," Freud saw transference as a "false connection" or a "displacement" of the patient's unconscious ideas about childhood relationships with parents and other early caregivers onto the person of the therapist. He also saw transference as a symptom in the patient that was an "obstacle" to the treatment and a resistance to the therapeutic work. Both men treated their patients' transferences as symptoms, as they would treat any other symptom, by the use of catharsis, hypnosis and suggestion.⁵ Their pre-psychoanalytic method relied on the personal influence ("suggestion") of the doctor upon the patient and the patient's symptom(s).

Sadly, I must note that the 1880s pre-psychoanalytic practices of catharsis, suggestion, hypnosis and reassurance have become staples today in the pastoral care and counseling practices of many chaplains and pastoral counselors. Raymond Lawrence has illustrated a number of examples of these pastoral care problems in his *Nine Clinical Cases: The Soul of Pastoral Care and Counseling*.⁶ Many of us seem to have lost touch with the development of psychoanalytic theory and technique that has emerged in the last one hundred and twenty-five years. For too many, it is as though the concepts of transference and countertransference do not exist, even though all humans act them out with each other daily. This problematic requires a more critical review, to which this paper is devoted and from which I draw some conclusions. That review begins with a case from our own era.

CASE TWO

A number of years ago, I worked at a major medical center where, in addition to Clinical Pastoral Education supervision, my work focused on

pastoral care to Lutheran patients. One day, after a referral from her pastor, I entered the room of a sixty-two-year-old woman whom I will call Mrs. A. She was admitted due to a history of chronic and severe hives. When I introduced myself as "the Lutheran chaplain" she immediately burst into tears. Mrs. A sobbed and talked non-stop for nearly an hour, sharing intimate details about her life, as well as stories about her involvement in the life of her congregation, until I brought this initial visit to a close with an agreement that we would pick up the conversation again the next day. At her request, we had a prayer and I concluded the visit, although she would have preferred to continue for another hour or more. A rather bizarre aspect of the visit was her total idealization and desperate trust of me, a person she had never met before. This was the most disproportionately positive and idealizing transference I had ever experienced, and I mused during and after the visit about what Mrs. A's behavior meant.

The second visit was more of the same: more tears, more personal revelation about her illness and treatment, her husband's alcoholism, his verbal abuse, her painful relationships with his children from his previous marriage, her early life as the child of an alcoholic father and an abused mother, and more idealization of me. Her internal pressure to talk and cry began to subside by the end of our fourth visit as her discharge was imminent. After several days in the hospital she learned that her hives resulted from an allergy to acetylsalicylic acid, the active ingredient in aspirin that is also present in certain vegetables, fruits, nuts, seeds and seasonings. Armed with relief at a better diagnosis of her physical condition, a medical treatment plan, dietary instructions, and four sessions of feeling heard and understood by her chaplain, she was preparing for discharge. Curiously, her positive and idealizing transference toward me remained as strong and desperate as it had been in the first visit.

My countertransference to Mrs. A is already implied in the above description of her behavior toward me. I was amazed at the strength and tenacity of her transference. I experienced her sudden, desperate, dependent and erotically tinged attachment to me through the lens of my internalized early relationship to my mother. My mother had been overly dependent on me for solace regarding her own problems with my father and other family members. At the unconscious level, my pastoral relationship with Mrs. A occurred at the nexus between her Oedipal situation with her chaotic alco-

holic parents and my own Oedipal situation as the oldest son of my anxious and depressed mother and father.

Through my own prior psychoanalysis and clinical training, I had explored my over-involvement with my mother. This enabled me to set boundaries on my relationship with Mrs. A that were based on my self-understanding. My deeper self-knowledge enabled me to deploy my countertransference as an instrument to empathically listen to and understand the patient and her powerful transference. Mastery of my own countertransference is another way to describe my constructive "use of self" to stay in dialogue with Mrs. A rather than fleeing the room (as Dr. Breuer had done with Anna O). Reactively offering prayer, advice, or reassurance would have been a means of psychic flight from Mrs. A and her anxious confusion. Instead, through empathic listening, I explored the patient's inner chaos, her confused and permeable personal boundaries, and I set time boundaries on her effusive self-revelation. For example, I kept each of our visits to less than an hour, and through interpretations I helped her move toward deeper self-understanding. My pastoral care focused on her immediate needs to unburden her anxiety, fear and emotional pain, although it was clear that her needs for personal psychotherapy would extend far beyond her few days of hospitalization. As discharge occurred I referred her to a pastoral counselor in her community for follow up care because she lived about 135 miles from our medical center.

DIFFERENTIAL DIAGNOSIS

Three years later I made a presentation to a group of CPE supervisors on the topic of transference and countertransference in pastoral care and pastoral care supervision. I included the case of Mrs. A as an illustration. One supervisor's response focused exclusively on her tears, insisting that the case was about her grief rather than her transference. Clearly there were a few aspects of grief in this patient's self-presentation, but in fact her litany of pain and suffering included no mention of the loss or death of significant people in her life except for her divorce from her first husband some twenty-eight years earlier. Rather, her tears were part of a far more complicated clinical picture. That picture included her high anxiety, low self-esteem, deep depression, and clinging dependency that were embedded in her history of verbal abuse beginning in relationships with her cha-

otic, critical and alcoholic parents. These symptoms were repeated in her masochistic dependency on her abusive and sadistic husband. Apposite to this painful history was her idealizing and dependent transference onto her home pastor and onto me. She seemed to see us as photo-negatives of her relationships to her family of origin and her nuclear family. Her pattern of splitting her relationships into “good” and “bad” was blatant, but I chose not to interpret her proclivity for splitting because the limits of a brief hospitalization provided insufficient time to work through this deep-seated and multi-faceted issue.

After this presentation, I asked myself some questions. How is it possible that a CPE supervisor could hear this clinical presentation and only conclude that the patient was grieving? How often do chaplains apply bereavement care to situations in which grief is not actually the presenting problem? From a clinical theory-based perspective, doing so could reduce the chaplain’s function to that of a “one-trick pony” who sees most patients as in need of bereavement care. Perhaps in a more apt metaphor, the chaplain becomes a current-day Procrustes.⁷

Before making a pastoral diagnosis, the clinician must first be able to recognize symptoms.⁸ In examining the case of Mrs. A., it is helpful to pose some questions that could actually be part of a supervisor’s work with the chaplain. Does the chaplain/trainee recognize a disproportionately positive transference as a symptom of possible deeper trouble? Or, on the other hand, is the chaplain flattered to be treated in such a positive manner and unaware of any symptomatic implications? If the first option pertains, the chaplain might pick up on the unusually positive transference and further engage the patient to assess whether a referral for pastoral counseling or some other treatment modality is indicated. The chaplain might assess whether the patient is able to view these symptoms as issues to be further explored, and whether she desires to do so. On the other hand, if the chaplain is flattered by a patient’s positive transference that is not recognized as such, their relationship may devolve into some form of collusion. Collusive possibilities include mutual admiration, or acting out their respective unconsciously held early life roles so that the patient’s current life crisis is denied or treated with suggestion and/or facile reassurance. Typical examples of suggestion and reassurance include the misuse of God-talk or prayer. The real question, then, is: Does the chaplain listen for any deep soul-pain needing to be expressed—pain that may be spoken or enacted in the transference?

Mrs. A also enacted other symptoms that hint of more complex dynamics. She seemed unaware of time boundaries in that she could have talked for several hours at a time. She revealed deep personal information almost immediately in the first visit rather than following a more socially appropriate pattern of beginning the pastoral relationship with a bit of reserve while getting acquainted. Problems with time boundaries and engagement in premature intimacy are classic symptoms of personality disorders-issues requiring treatment that far exceeds the parameters of brief pastoral care.

In spite of the above pastoral diagnostic claims, let us review the classic symptoms of grief and differentiate Mrs. A's symptoms from those of grief. Judith Viorst, in her book *Necessary Losses*, describes the entire spectrum of human development from birth to old age and death as a series of normative or "necessary" losses.⁹ As Viorst's thesis goes, every life transition involves the grief of giving up the current and familiar stage of life to experience and work through the anxiety and promise of the next. In this sense, we are all certainly in grief all of the time as we cope with our respective and normative life-stage transitions.¹⁰ For Viorst, an indicator of human health is one's capacity, in spite of these losses, to experience curiosity and investment in interpersonal relationships and to live in hope and promise for each new event or developmental stage of life.

On the other hand, the classic symptoms of acute grief as a syndrome are more pronounced. Psychologically we see numbness; crying that comes in waves in response to thoughts or memories of the deceased; sadness and yearning; relief and guilt; anxiety, worry and fear; difficulty finishing tasks or concentrating; forgetfulness; indecisiveness; and denial and anger. Physiologically we find exhaustion; muscle tightness or weakness; body pains; restlessness; lack of energy; insomnia; loss of appetite; overeating; nausea; a hollow stomach; indigestion; diarrhea; and fears of illness and death. Complicated grief generally encompasses the same symptoms, but they are prolonged in duration and/or heightened in intensity. In a few cases psychotic features may also appear.¹¹

In sum, I have provided three distinctly different symptom pictures. First, Mrs. A's ensemble of symptoms includes a history of verbal violence and abuse during her childhood, adolescence and adult life. There is the split between her anxious, clinging positive transference onto her chaplain and local pastor, both of whom she idealizes, and, on the other hand, there

is her hurt, angry, negative transference onto her alcoholic parents, spouse, and spouse's children, all of whom she decries. Additionally, she demonstrated interpersonal boundary issues including premature intimacy and lack of capacity to impose limits on time spent in dialogue. Finally, she displayed a high level of labile emotional intensity regarding her anxiety, fear, sadness and erotically tinged dependence on the chaplain.¹²

In the second symptom picture, I have described the characteristics of normal human development in which loss is experienced and worked through in each of life's major and micro developmental transitions. Third, I have outlined the symptoms of acute grief and bereavement. And finally I have described the symptoms of complicated and prolonged grief. Although there are a few similarities between Mrs. A's symptom picture and the other three options, Mrs. A's symptoms were largely different. Her suffering bore some resemblance to complicated or prolonged grief, but it is more likely that she was dealing with developmental arrest at an early life stage. A consequence of early developmental arrest is that passage through each subsequent developmental stage is partially compromised. The outcome in Mrs. A's case included relational boundary confusion, difficulty with affect regulation, and insecure attachment.

Having greater diagnostic clarity about the symptoms in Mrs. A's transference, I now turn to explore the phenomena of transference and countertransference in terms of what they are, where they come from, and some of the clinical opportunities and dangers they present. I also consider how transference and countertransference can work together for illness or for healing, moving pastoral practice beyond the catharsis of grief to consider many additional issues our patients and trainees can explore in pastoral dialogue.

SOURCES OF TRANSFERENCE AND COUNTERTRANSFERENCE: THE OEDIPAL TRIANGLE

Where do transference and countertransference come from, and what meaning do these phenomena have? For every human being, these phenomena arise out of the early Oedipal situation. Freud first discovered the Oedipus complex in himself during his self-analysis that he began in 1897, and he subsequently determined that it normatively develops in children during the ages of four to five or six. Later, Melanie Klein found pro-

nounced Oedipal dynamics in children as young as two years and nine months of age.¹³ Laplanche and Pontalis define the Oedipus complex as an

organized body of loving and hostile wishes which the child experiences toward its parents. In its so-called positive form, the complex appears as in the story of Oedipus Rex: a desire for the death of the rival—the parent of the same sex—and a sexual desire for the parent of the opposite sex. In its negative form, we find the reverse picture: love for the parent of the same sex, and jealous hatred for the parent of the opposite sex. In fact, the two versions are to be found in varying degrees in what is known as the complete form of the complex.¹⁴

By 1909, Freud's colleague Sandor Ferenczi had demonstrated that patients unconsciously placed their doctor in the role of loved or feared parental figures.¹⁵ So transference (and countertransference, as was later understood) is a repetition of one's early Oedipal dynamics that emerges in the therapeutic or supervisory relationship as erotic or hostile feelings toward the patient, therapist or supervisor. Freud actually first mentioned transference in his publications of 1910 and 1912, describing it as

prototypes or imagos (chiefly the imago of the father, but also of the mother, brother, etc.): the doctor is inserted 'into one of the psychical "series" which the patient has already formed.'¹⁶

Along these lines, Freud described how the patient's emotion-laden Oedipal relationships are re-lived in the transference to the analyst. In other words, the patient or trainee experiences the therapist, chaplain, or supervisor in the same emotional hues and dynamics that pertained in his/her original Oedipal relationships of childhood. Unconsciously, the patient's or trainee's libido and aggression coalesce and become focused on the person of the therapist/supervisor.

This was the case with Anna O., a very bright, and modest twenty-one-year-old woman who fell ill while caring for her father during his protracted illness that finally led to his death. Her father's nursing care needs had already exhausted Anna's mother, and then the burden of round-the-clock care fell upon Anna. She also became exhausted while trying to cope emotionally with having to bathe and toilet her own father. One night, while dozing at her father's bedside with her arm draped over the back of her chair, her arm "went to sleep" due to a partial cut-off of blood supply. After awakening, the symptoms persisted and she was diagnosed as having a hysterical paralysis of the arm, the arm and hand that had bathed and

helped toilet her father. As the saying goes in our time, she had encountered “too much information” about her forbidden Oedipal first love.¹⁷

During her two-year therapeutic relationship with Dr. Breuer, a man some twenty years her senior, Anna O. fell in love with him. In the transference, she re-experienced the feelings she felt forbidden to act upon in her loving care of her father. The drama of the Oedipal triangle had re-emerged in relation to Dr. Breuer.

TRANSFERENCE AND COUNTERTRANSFERENCE AS RESISTANCE

It is significant that Freud mentions transference at least eighty-nine times in the twenty-three volumes of the standard edition of his writings but only mentions countertransference five times.¹⁸ Moreover, there is very little serious consideration of countertransference in the psychoanalytic literature until the early 1950's—about thirty-five years after Freud's last published reference in 1915. As Heinrich Racker put it in 1953,

To my mind, these facts are due. . .to a resistance. Among psychoanalytic subjects countertransference is treated somewhat like a child of whom the parents are ashamed.¹⁹

It is far easier for analysts, psychotherapists, supervisors and chaplains to attend to the transferences of our patients and trainees than it is for us to look at our own countertransference. After all, countertransference involves the same early Oedipal dynamics and processes as our patients' transferences. Unfortunately, after some analysts complete their training, and after some chaplains are certified, they begin to behave as though they have graduated from the need for critical introspection. In some way, shape or form, resistance is always both latent and manifest in transference and countertransference, and in our perennial desire to avoid its recognition.

When a psychotherapy or supervisory relationship becomes boring or repetitious, or seems to be going nowhere, this may be a sign of resistance. One or both parties may be resisting the investigation of an issue by collusion to deny and avoid it.

CASE THREE

A brief case example will illustrate this. In the 1990's I was doing pastoral counseling in an office of a church. One day a patient, whom I will call Mrs. B, failed to show up for her appointment. When she arrived for

therapy the following week, she admitted with shame and embarrassment that she had come to the church the previous week but the door had been locked. She rang the doorbell, and the church secretary let her in. Immediately, she became furiously jealous of the church secretary and was convinced that the door was locked because the secretary and I were having an affair. Rather than coming to my office for her appointment she left in a huff and went home.

In Mrs. B's transference-love toward me, we can see resistance operative on my part and hers. The incident with the doorbell and the church secretary followed a period of somewhat unproductive therapy. In retrospect, it suddenly became apparent to me that I had been denying Mrs. B's amorous transference toward me, and that the therapeutic relationship could go no farther until we addressed her erotic transference that I was ignoring. It was necessary to process our transference-countertransference dynamics in order to get the therapeutic process unstuck. First, Mrs. B unconsciously projected her own sexual urges onto the secretary and me. She acted out her jealousy by skipping our therapy session and leaving the church in a tantrum. Paradoxically, Mrs. B's outburst and my interpretation of this episode moved the therapy relationship out of stasis.

Another alternative would have been to act out the transference and countertransference. However, if Mrs. B and I were to have an affair, we would no longer be doing psychotherapy. The attempt of either the patient or the therapist, or both, to have an affair would constitute a destructive attack upon the therapy.

COUNTERTRANSFERENCE AS AN INSTRUMENT OF KNOWLEDGE

Countertransference, when rightly understood and used, can be one of our most powerful tools in pastoral care, pastoral counseling and clinical supervision. Our countertransference can become an instrument of knowledge.

From 1948 to 1953 a major theoretical shift occurred in psychoanalytic theory. In her article, "On Countertransference", Paula Heimann said:

The analyst's response to his patient within the analytic situation represents one of the most important tools for his work. The analyst's countertransference is an instrument of research into the patient's unconscious. . . . The aim of the analyst's own analysis is . . . to enable him to sustain the feelings which are stirred in him, as opposed to discharging them (as the

patient does), in order to subordinate them to the analytic task in which he functions as the patient's mirror reflection.²⁰

Considered in this way, countertransference may be deployed as an instrument through which the analyst receives, reflects upon, and comes to understand the transference feelings, desires and dynamics that the patient projects. Founded on an expectation that the patient's or trainee's early Oedipal situation will express itself somehow in the transference, the therapist or supervisor is always alert for its arrival in some way, shape or form. Based on this introjective analytic reception into the analyst's countertransference, he/she explores and analyzes the dynamic meaning of the patient's or trainee's transference and begins to formulate interpretations. To illustrate, I return to the case of Mrs. B presented above.

As a child, Mrs. B grew up in an over-close, eroticized relationship to her father and an intensely competitive relationship with her troubled mother as they vied with each other for the affections of her father. For a number of sessions following the doorbell incident at the church, our work in therapy centered upon exploring, untangling, and interpreting these early Oedipal dynamics as they had surfaced in our therapy relationship. We began to explore her erotic paternal transference toward me. The critical incident nudged me to consider my aforementioned analytic understanding of my over-close, eroticized childhood relationship with my own mother. This self-knowledge prepared me to use my countertransference as an antenna or instrument to receive, understand, and interpret the jealous and infatuated transference Mrs. B had enacted toward the church secretary and me.

A second contribution to the consideration of countertransference as a therapeutic tool or instrument was made by Roger Money-Kyrle whose thesis is stated in the title of his article, "Normal Countertransference and Some of its Deviations."²¹ He wrote,

We used to think of countertransference mainly as a disturbance to be analyzed away in ourselves. We now also think of it as having its causes, and effects, in the patient, and therefore as an indication of something to be analyzed in him.... Of course (this)... does not imply that it has ceased to be a serious impediment.²²

In other words, the dynamics of the patient's own transference generate what the analyst feels in his/her countertransference. To the extent that the analyst's countertransference does not distort what it receives, and to the extent that the analyst is not unduly disturbed by what he or she re-

ceives from the patient, this knowledge can be used to understand the patient's internal world. It can serve as a basis for construction of the next interpretation.

Another Kleinian, W.R. Bion²³ distinguished "normal" forms of projective identification from the "pathological" ones, and saw normal projective identification as what happens in empathy, and in the acquisition of knowledge about other objects and the world. Because transference and countertransference are seen as particular species of projective identification, it becomes possible—indeed fruitful—to think of both transference and countertransference as methods of inquiry. "Normal countertransference" occurs all the time in effective psychotherapeutic, supervisory or pastoral care relationships, and if the clinician has undergone personal analysis or psychotherapy sufficient to recognize and achieve awareness of his or her countertransference, he or she can use the countertransference as an instrument for deep understanding of the patient.

Notoriously, patients can misuse their transference to seduce or challenge the analyst, resist the treatment, or tease out what the analyst will do in response to this or that particular ploy. Regrettably, therapists, chaplains and supervisors can also misuse their countertransference to become predators of their patients and trainees.

More constructively, the analyst, supervisor, or chaplain can make use of countertransference to assess the unconscious process of the patient, whether to understand the patient's resistance or to cooperate and work within the therapeutic dyad.²⁴ To summarize, we are on notice that countertransference can serve as an important instrument of knowledge, but it also remains an occupational hazard.

TRANSFERENCE NEUROSIS AND COUNTERTRANSFERENCE NEUROSIS

Let us now turn our attention, first, to the notion of the "transference neurosis" and then to the "countertransference neurosis." These two sets of psychic phenomena operate simultaneously in psychotherapy and supervision, in apposition to each other.

As his psychoanalytic theory matured, Freud came to see the notion of transference as a process around which the entire treatment revolves. This point cannot be stressed too much. Stemming from early Oedipal relation-

ships, the patient's libido and aggression coalesce and become focused upon the person of the analyst. The dynamics of the early infantile Oedipal conflicts and their derivatives emerge into what he called the "transference-neurosis." As Freud put it,

We regularly succeed in giving all the symptoms of the illness a new transference meaning and in replacing the patient's ordinary neurosis by a 'transference-neurosis' of which he can be cured by the therapeutic work.²⁵

The patient, embodying a neurosis that his early life relationships have pre-shaped in him, relates in this neurotic manner toward the analyst. As a result, the patient's illness becomes manifest all over again in relation to the analyst. Only the Oedipal constellation of internalized parental and pastoral objects could have made possible the instantaneous transference response of Mrs. A. who burst into tears when I—a perfect stranger—introduced myself as "the Lutheran chaplain." Elsewhere Freud describes the transference-neurosis as an "artificial illness." That is, in relation to the analyst, the patient develops a new illness that is a facsimile of the neurosis that brought him or her to treatment. The transference-neurosis is further described through the use of Freud's concept of the repetition compulsion. That is, patients spontaneously and compulsively repeat early childhood Oedipal situations and emotions in relation to their therapist in the here and now. The cases of Anna O., Mrs. A. and Mrs. B. are striking examples of the spontaneous, compulsive, and insistent emergence of transference reactions. Working in the medium of the patient's transference, the analyst treats the transference-neurosis. As this neurosis is resolved, so is the neurosis that first brought the patient into treatment. In other words, Freud came to understand the transference neurosis as a description of the patient's side of the therapeutic relationship *per se*.

I now turn from the patient's transference neurosis to consider the therapist's, supervisor's, or chaplain's countertransference neurosis. This is the other half of the therapeutic relationship. In doing so, the perspective of Heinrich Racker is our guide. He observes,

In the same way as the original neurosis and the transference neurosis, the 'countertransference neurosis' is also centered in the Oedipus complex. At this level every male patient fundamentally represents the father and every female patient the mother. In a similar fashion to the transference neurosis, the real factors such as the age of the object (in this case the patient), his bodily appearance, his general psychological state, his moods,

etc., evoke some aspect or other of what is already preformed in the analyst as his inner oedipal situation.²⁶

Reflecting again on the case of Mrs. B, I realized that although she was only five or six years older than me, I always experienced her as being from my mother's generation rather than from my own. I was aware of enjoying her positive transference toward me, but the maternal aspects of her transference did not elicit the kind of erotic countertransference from which I would find her to be sexually tempting. I loved her like I would love a mother, but the part of my counter-transference that I did not recognize was the way in which her transference elicited my history of collusion with my internalized mother—a circumstance that persisted throughout my childhood and adolescence because neither my mother nor I understood or resolved this collusion. I was re-living my unrecognized early life adherence to the incest taboo in my relationship to Mrs. B—a situation that inhibited my interpretation of the Eros in our relationship. My doing so created a maddening, collusive, therapeutic stasis. Mrs. B displaced her erotic frustration by acting out in response to the locked door and the church secretary who became, for her, "the other woman." Such was the countertransference neurosis in which I was embedded.

The therapist or supervisor must be able to differentiate between two powerful dimensions of countertransference. First, through countertransference he or she is in touch with the patient's or trainee's struggle with the primary process desires of the id as the ego copes with life in the real, interpersonal world. Second, the therapist or supervisor identifies with the patient's, or trainee's internal objects that are simultaneously being projected into the therapist or supervisor via the transference. Without some kind of internal filter, or instrument, the therapist or supervisor would become overwhelmed by the internal objects that the patient or trainee projects. Racker describes this phenomenon as "drowning in the countertransference."²⁷ In my case with Mrs. B, I could be more accurately described as adrift in my countertransference neurosis until the doorbell crisis finally got my attention.

Racker describes the function of countertransference as the capacity of the therapist or supervisor to engage in a "double life" characterized by "healthy splitting." The therapist or supervisor "is able to divide his ego into an experiencing, irrational; and into a rational, observing one."²⁸ First, the "experiencing, irrational" side of the split is the therapist's or supervisor's

capacity for empathy with the dynamics of the patient or trainee, no matter how irrational and chaotic those dynamics may be. On the other hand, the "rational, observing" side of the split is the therapist or supervisor's capacity to think coherently about the meaning of the irrational and chaotic dynamics received by the first side of the split. Accordingly, the therapist or supervisor is able to think diagnostically and psycho-dynamically about the patient or trainee's irrational, chaotic transference projections and to make interpretations that reduce anxiety and help the "clinical couple" to reflect upon their emotional and interpersonal experiences constructively.

THE CLINICAL COUPLE

Having discussed at length some of the key aspects of transference and countertransference, I have now arrived at the point where I can talk about the two persons' work together as a "clinical couple." Through the discussion of the Oedipal origins of transference and countertransference, I have shown that the therapeutic, pastoral care or supervisory dyad has its roots in the dim, developmental origins of both persons. As Racker put it, "transference and countertransference represent two components of a unity, mutually giving life to each other and creating the interpersonal relation of the analytic situation."²⁹ This intimate dyad not only has Oedipal origins but is also rooted in the primal situation of the infant at its mother's breast. Hence there is an often-used metaphor in the Kleinian psychoanalytic literature that describes a productive therapy session as a "good feeding."

The next question concerns when, in the therapeutic, pastoral or supervisory relationship transference and countertransference begin. Racker's answer is unequivocal: "The transference is a constant reality which begins even before the first interview."³⁰ It is present already in the patient's anxious deliberations about whether to get into therapy at all and in the patient's phantasies about what the therapist will be like. By the time the patient selects a therapist and calls to make the first appointment the transference has been going on for some time. We clinicians would therefore be wise to have these facts in mind as we take the call.

For clinicians, the countertransference also begins very early. When a patient calls to make the first appointment, the clinician is already listening carefully for diagnostic clues, for treatment implications of the presenting

problem, and for a sense of whether this is a patient whom the therapist can effectively treat.

The same transference dynamics are operative for people deciding whether and where to apply for clinical pastoral education or training. Many pastors and seminarians have already heard "CPE war stories" and approach the application for CPE/T with trepidation.

Simultaneously, countertransference also occurs early in the mind of the supervisor. As the supervisor plans a unit of training he or she is concerned about the student selection process, expressing many typical questions: Is this a trainee I can manage in supervision? What is this trainee looking for from me and from the training process? How will this trainee relate to peers, to clinicians of other disciplines, and above all to patients and families? Can I trust this person to function ethically in the clinical and training settings? Does this person have the capacity to learn from experience? All of these questions and more are at play as the supervisor reviews each trainee's application. Finally, after all of these mutual preliminary expectations, the face-to-face clinical relationship, *per se*, begins.

REFLECTION

In the foregoing pages, I have used the lenses of transference and countertransference to explore clinical relationships from several perspectives. Three case examples were cited, and I have noted the self-consciousness and vulnerability to shame of the patient or trainee, on the one hand, and that of the therapist, chaplain or supervisor on the other. I have pointed out some avoidant tendencies of analysts, chaplains, supervisors and even Freud himself. Avoidance and other forms of resistance lead us to focus far more on the transference of those whom we treat or train than upon our own countertransference toward those in our care. That is, we are more comfortable externalizing or projecting our own conflicts and treating them in our patients and trainees.

I have noted the dynamics of our early Oedipal relationships that emerge in treatment and training relationships as the origin of the transference and countertransference. I have explored how resistance to making the unconscious become conscious is embedded in the transference of those we treat and train and how that resistance is also embedded in our countertransference, impeding our effectiveness as therapists, chaplains

and supervisors. Nevertheless, I have challenged clinicians to consider how our countertransference may be deployed as an instrument to obtain deep knowledge about our patients, trainees and ourselves. I invite clinicians to consider how the transference neurosis and the countertransference neurosis are naturally occurring human modes of relationship that may either help or impede our healing and training relationships.

This article began with the assertion that the phenomena of transference and countertransference have an uneasy history. I traced the story of how understandings of transference and countertransference developed, how they both embody and provoke resistance, and how they simultaneously bear vital information about the internal worlds of the patient, the trainee, the therapist and the supervisor. We noted that sufficient self-investigation through prior personal psychodynamic psychotherapy can make it possible for pastoral clinicians to overcome their own resistance, and work through the resistance of those in their care. Through painstaking work in authentic relationship clinicians can deploy the information contained in the transference and countertransference for the healing, growth and deeper self-understanding of both persons. However, I noted that this hopeful, constructive outcome is not always achieved in the real clinical pastoral world.

Too often resistance wins the day as the fear, shame and anxiety of patient, trainee and supervisor leave persons clinging to defenses that are familiar but counterproductive. I have noted that the 1880s pre-psychoanalytic practices of catharsis, suggestion, hypnosis and reassurance are widespread in the practices of many of today's chaplains and pastoral counselors. In these cases, the transference neurosis of a patient or trainee intersects with the countertransference neurosis of a therapist, chaplain or supervisor, and neither is aware of being awash in these neuroses. The psychoanalytic community refers to this state of affairs as *folie à deux*, a syndrome in which symptoms of a delusional belief are transmitted from one individual to another. Patient and chaplain—or trainee and supervisor—"get crazy" together. A host of ethical and malpractice implications follow from such a fused state of like-mindedness.

I have already named the obvious scenario of sexual acting out between chaplain and patient or supervisor and trainee. More pedestrian, and more frequently, the chaplain may avoid listening to the deep soul pain of a patient's dynamics by quick recourse to prayer, God-talk or other sacer-

dotal ministrations that the patient did not request and may not desire. The operant questions are: Whose need is being met here? Did the use of prayer or another rite arise naturally out of the patient's own expressed pain and felt need?

IMPLICATIONS FOR SUPERVISORY CURRICULA

A prior set of questions may, however, get more to the root of the problem, namely, the issues of the philosophy and design of supervisory curricula. Pertinent questions include: Does any element of a program's training curriculum directly address transference and countertransference, or introduce psychoanalytic theory *per se*? It is easy for the training curriculum to become over-burdened, and paradoxically trivialized by too many foci. Important topics include crisis intervention theory, grief and bereavement theory, pastoral theology, group theory, family systems theory, medical ethics, liberation theology, feminist theory, post-colonial theory, intercultural theory, white privilege theory, addictions theory, and specializations in such areas as palliative care, pediatrics, emergency pastoral care, mental health and many more. Similar lengthy lists could be made for training programs in pastoral counseling, or supervisory CPE/T.

Finally, trainees should be exposed to pastoral care and counseling literature that introduces them to the phenomena of transference and countertransference and assists them in integrating knowledge of these processes into their praxis. Clearly the best current resource is Pamela Cooper-White's *Shared Wisdom: Use of Self in Pastoral Care and Counseling*.³¹ Her post-modern approach relies upon and "expands"³¹ the insights of the neo-Kleinian perspective I espouse in this article.

This plethora of options begs the following questions: What are the core competencies essential to functioning as a pastoral clinician in any of these professional tracks? What competence does a clinician need to possess in order to protect him or herself from the patient, and to protect the patient from him or herself? A full treatment of these curricular issues lies outside the scope of this discussion, but this consideration of transference and countertransference indicates a profound yet basic element of what lies at the core of being a competent pastoral clinician.

NOTES

- 1 Ernest Jones, *The Life and Work of Sigmund Freud*, Vol. 1 (New York: Basic Books, 1953), 223-226.
- 2 Jones, *The Life and Work of Sigmund Freud*, 226.
- 3 Josef Breuer and Sigmund Freud, "Studies On Hysteria," in *The Standard Edition of the Complete Psychological Works of Sigmund Freud* referred to hereafter as *S.E.*, Vol. 2 (London, The Hogarth Press and the Institute of Psycho-Analysis, 1955), 21-47; and Jones, *The Life and Work of Sigmund Freud*, 221-267 (see especially pp. 223-226).
- 4 Breuer and Freud, "Studies On Hysteria", 1-312.
- 5 Breuer and Freud, "Studies On Hysteria," 302.
- 6 Raymond J. Lawrence, *Nine Clinical Cases: The Soul of Pastoral Care and Counseling*, (self-pub., 2015).
- 7 Sabine G. Oswalt, "Procrustes," in *Concise Encyclopedia of Greek and Roman Mythology* (Chicago: Follett, 1966), 249. According to Greek mythology, Procrustes had a house by the side of the road where he provided hospitality to passing travelers. After feeding them a good meal, he gave them a night's rest on his very special bed that, according to him, adjusted itself to the body length of its occupant. What Procrustes did not tell his guests was that if the guest was too short, he stretched them on a rack until they fit the bed, and if they were too tall, he chopped their legs off to make them fit.
- 8 Paul W. Pruyser, *The Minister as Diagnostician* (Philadelphia: Westminster Press, 1976); and, more recently, Nancy J. Ramsay, *Pastoral Diagnosis: A Resource for Ministries of Care and Counseling* (Minneapolis: Fortress Press, 1998).
- 9 Judith Viorst, *Necessary Losses: The Loves, Illusions, Dependencies and Impossible Expectations that All of Us Have To Give Up in Order to Grow* (New York: Fawcett Gold Medal, 1986).
- 10 Viorst, *Necessary Losses*.
- 11 Erich Lindemann, "Symptomatology and Management of Acute Grief," *American Journal of Psychiatry* 101 (1944), pp. 141-48. Lindemann worked at Massachusetts General Hospital in Boston as the chief of psychiatry and was noted for his extensive study on the effects of traumatic events on survivors and families after the Coconut Grove nightclub fire in 1942. He was the first to describe grief as a clinical syndrome. See also Elizabeth Kübler-Ross, *On Death and Dying* (New York: Scribner, 1969); and J. William Worden, *Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner*, 4th edition, (New York: Springer Publishing, 2008). Worden's research and publication on grief is perhaps the leading current work in the field.
- 12 *American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (Arlington, VA: American Psychiatric Association, 2013).
- 13 Hanna Segal, *Klein* (London: Karnac Books, 1989), 46; and Melanie Klein, "The Psychological Foundations of Child Analysis," *The Psychoanalysis of Children*, [1926], in *The Writings of Melanie Klein*, Vol. 2, (New York: The Free Press, 1975), 3-15, see especially pp. 3-4.

- 14 Jean Laplanche, and Jean-Bertrand Pontalis, *The Language of Psycho-Analysis*, trans. Donald Nicholson-Smith (New York: W.W. Norton & Company, 1973), 282-87.
- 15 Sandor Ferenczi, "Introjection and Transference", in Sandor Ferenczi, *First Contributions to Psychoanalysis* (1909), 35-39; and Laplanche, and Pontalis, *The Language of Psycho-Analysis*, 457-58.
- 16 Laplanche and Pontalis, *The Language of Psychoanalysis*, 458; and Sigmund Freud, *S.E.*, 12: 104.
- 17 Josef Breuer and Sigmund Freud, "Studies On Hysteria," 21-47.
- 18 Freud, *S.E.*, 24: 258, 391.
- 19 Heinrich Racker, "The Countertransference Neurosis," in Heinrich Racker, *Transference and Counter-Transference*, (Madison, CT: International Universities Press, 1968), 105-126.
- 20 Paula Heimann, *International Journal of Psycho-Analysis*, 31 (1950): 81-84; reprinted in Andrew C. Furman and Steven T. Levy, eds., *Influential Papers from the 1950s* (London: Karnac, 2003), 27-34.
- 21 Roger Money-Kyrle, "Normal Countertransference and Some of its Deviations," *International Journal of Psycho-Analysis*, 37 (1956): 360-366; reprinted in Furman and Levy, *Influential Papers from the 1950s*, 81-94.
- 22 Money-Kyrle, "Normal Countertransference and Some of its Deviations," 81-94.
- 23 W.R. Bion, "Attacks on Linking," *International Journal of Psycho-Analysis*, 40, nos. 5-6, (1959); reprinted in W.R. Bion, *Second Thoughts: Selected Papers on Psycho-Analysis* (Northvale, NJ: Jason Aronson, 1993), 93-109.
- 24 W.R. Bion, "A Theory of Thinking," *International Journal of Psychoanalysis*, 43 (1962); 306-310; reprinted in Bion, *Second Thoughts: Selected Papers on Psycho-Analysis*, 1993, 110-119.
- 25 Sigmund Freud, "Remembering, Repeating and Working-Through," in *S.E.*, 12: 154.
- 26 Racker, "The Countertransference Neurosis," 62.
- 27 Heinrich Racker, "The Meanings and Uses of Countertransference," in Racker, *Transference and Countertransference*, 132.
- 28 Heinrich Racker, "Classical and Present Techniques in Psycho-Analysis," *Transference and Countertransference*, , 62.
- 29 Racker, "Classical and Present Techniques in Psycho-Analysis," 59.
- 30 Racker, "Classical and Present Techniques in Psycho-Analysis," 56.
- 31 Pamela Cooper-White, *Shared Wisdom: Use of Self in Pastoral Care and Counseling* (Minneapolis: Fortress Press, 2004), 5.