9. The Role of the Analyst's Personality in Therapy

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From the earliest years of psychoanalytic therapy, the fact that the analyst, as a factor in the analytic situation, has to be taken into consideration, has not been overlooked. In an attempt to maintain a scientific setting, Freud sought to make the personal equation of the analyst as inconspicuous as possible. To this end, it was recommended that there should be no social contact between patient and therapist, that the patient should know as few facts as possible about the analyst's life, and that the analyst should sit behind the couch so that any changes in his facial expression would be unobserved. In this way, it was hoped that an objective neutral atmosphere would be created, in which the patient, without distraction, could present his own life problems and project upon the analyst any role needed.

From the beginning, Freud realized that complete anonymity could not be attained. For example, the sex of the analyst would be apparent, his approximate age could not be concealed, and whether he had a cold or not might be evident. The patient might learn something about him from others also, etc. These facts were thought to be regrettable defects in the sensitive instrument, the analyst, that was to be used to study the patient.

After a time, it became apparent that other problems might arise, that in spite of all precautions some problem of the analyst might lead to his emotional involvement in the situation. For example, an attractive female patient might succeed in stirring him erotically, especially if his own love life was unsatisfactory, or a hostile patient might succeed in finding a vulnerable spot and rouse the analyst's defensiveness or anger. In short, any weakness in the therapist might accidentally be exploited to the detriment of successful treatment. Freud pointed out that when these situations happened, something comparable to the acting out of the patient took place on the part of the analyst, and so he called them countertransference phenomena. Eventually, i.e. by 1920, the solution for such problems was sought in the analysis of the analyst. In this way, it was hoped that the analyst's objectivity would be improved. However, most of the so called "training" analyses, at first, were very brief, usually not more than six months at most. Consequently what happened in many cases was that the analyst became more expert at concealing his problems—that is, a better defense was formed as a result of intellectual insight, with a resulting increased rigidity of the analyst's personality. He became afraid to show warmth or spontaneous interest in the patient, not knowing where natural interest ended and his personal problems began. Ferenczi was the first to point out in the 1920s that the personal analysis of an analyst should, if anything, be longer and deeper than that of a patient, instead of the reverse. As time went on, this idea was taken over, so that today one of the most important aspects of training is a long and thorough personal analysis.

However, the goal, although not specifically so stated, in most institutes has been to make the analyst a clean sheet of paper, so to speak, so that the student often gets the feeling that after his analysis is completed, he ought to have no further problems. This also has had its unfortunate results. Perfection is an impossible and probably always a neurotic goal. The fear of having any shortcomings is increased, and since it is an impossible goal, there are always defects to be concealed. So defenses against imperfections are still erected with resulting rigidities of personality.

Ferenczi had a solution for this, and that was for the doctor to admit his mistakes to the patient. This suggestion did not meet with acceptance by most analysts. Freud, himself, thought it was dangerous in that it would tend to destroy the authority of the therapist. Nevertheless, since the early 1930s, a few analysts have worked along lines similar to Ferenczi's with good results, e.g. Sullivan, Fromm-Reichmann and myself—to name those whom I know most about, and, in the past ten years, there has been a movement in the direction of greater participation of the therapist in the analytic situation with a resulting greater frankness about his own role. This must include, at times, admission of mistakes, oversights due to personal problems, irritability, etc.

Today, countertransference studies frequently appear in the literature, and it is even possible that the tendency to stress the significance of the analyst's emotional reactions in the treatment has swung the emphasis too far in the opposite direction. We may be overvaluing the importance of this contribution to the analytic picture.

However, the present stress on the role of the analyst's personality has

opened new fields for observation. In the first place, the analyst need no longer feel defensive about being natural and spontaneous. This, in turn, makes it possible for the patient to react more genuinely. Nevertheless, it stresses the fact that the analytic situation is much more complicated than we earlier assumed. Thus, we can no longer simply suggest to the patient that whatever hostility he shows, clearly is displaced from his father or mother. We have to consider our own possible contribution to it. Thus, if he says, "I think you did not like what I said about you last time," the thoughtful analyst must carefully determine what his actual reaction was. In other words, did the patient correctly observe a resentment reaction. Such honesty is important in helping the patient in his appraisal of reality. At the same time, as implied earlier, it is possible in trying this new approach to lean over backwards in taking the blame, thus overlooking other factors.

However, setting aside criticisms of overenthusiastic use of the analyst's emotional reactions in understanding the patient, I wish to consider what new data about the patient is made available by awareness of emotional participation, and what it can teach us of the analyst's role in "cure."

In the first place, we must recognize that the analyst's blind spots are always a hazard. However, the hazard is greater when there is a stake in denying them. Not only is the patient needlessly confused by this, but, possibly even more important, denial aids the analyst in repressing his own possibility of insight. A frank discussion with the patient, encouraging him to tell all that he has observed or thinks he has observed may actually increase the analyst's insight into himself to the benefit of both. It is important to remember that unresolved difficulties always exist, that the understanding of oneself is never complete and that one can profitably seek, throughout a lifetime, for greater self knowledge. Such an attitude is an excellent safeguard against smug satisfaction and the Jehovah complex, which can keep us from a genuine sympathy and understanding of others.

Even when an irrational or countertransference attitude in the analyst has been demonstrated, new insight about the patient can be gained as a result of the experience if it is faced realistically.

Excessive acting out in the analytic situation would point to a blind spot in the analyst. What seems to happen in this situation is that the analyst happens from a genuine sympathy and understanding of others. The analyst then saw that the patient had made him anxious, that he had a very genuine fear of the patient's committing suicide, that he had been dealing with this anxiety by not listening, sticking his head in the sand, so to speak. The feeling was "if I don't notice this, it won't happen." This is not the end of this story. This analyst was not usually threatened by suicidal possibilities. He had dealt with many other difficult situations adequately. He had realized that the particular circumstances of this patient's life touched closely on a tragic situation in his own family. In other words, this patient, by his problem, threatened this analyst with an awareness of his anxiety about his own problem. Since his own difficulties were so deeply involved, the analyst wisely decided to transfer the patient to another analyst.

In another case, a young analyst was having difficulties with a dramatic acting-out type of hysterical woman. She reported that she was much worse since beginning treatment. Her husband became very alarmed and began calling the analyst, and corroborated her statement that she was much worse months before he was aware that nothing of importance in the therapy was happening. When the situation was examined, he recalled that this particular type of voice was characteristic of his mother, and that he had early developed an imperviousness to her tirades, and did not hear what his mother was saying. He had, all unwittingly, been treating the patient in the same way. Awareness of this not only benefited him, but told him something about the patient, which was helpful to her. In general, excessive acting out should always lead to the analyst's exploring his own contribution to the situation. Although, of course, we know that some patients tend to act out more than others—in their own right.

An analyst reported that he found it difficult to stay awake during hours with a certain patient. The patient talked in a flat, mumbling voice. There seemed to be no fluctuations indicating emotional content. The analyst found it almost impossible to listen. The problem was taken up in terms of "the patient is telling you something by this very attitude." The analyst thought about it—"he acts as if he thought I wouldn't be interested in him—but I actually act as if I weren't. I was interested in the beginning—what happened?" Then it occurred to him that on several occasions he had been aware of a slight feeling of anxiety over a dream reported by the patient, but the patient's monotonous voice had made it easy for him to overlook this. In one, the patient was in a small boat on a stormy sea. No help was around and the boat was sinking. In another, the patient was swimming far away from shore and could not get back. He was finally washed ashore dead. The analyst then saw that the patient had made him anxious, that he had a very genuine fear of the patient's committing suicide, that he had been dealing with this anxiety by not listening, sticking his head in the sand, so to speak. The feeling was "if I don't notice this, it won't happen." This is not the end of this story. This analyst was not usually threatened by suicidal possibilities. He had dealt with many other difficult situations adequately. He had realized that the particular circumstances of this patient's life touched closely on a tragic situation in his own family. In other words, this patient, by his problem, threatened this analyst with an awareness of his anxiety about his own problem. Since his own difficulties were so deeply involved, the analyst wisely decided to transfer the patient to another analyst.

and was threatening suicide. The analyst had been treating all this as evidence of her hostility, pointing out her desire for revenge, etc. Whatever he said seemed to make matters worse. He was urged to think how he felt towards this woman, not diagnostically, but personally. He realized he had felt a kind of hostile challenge in her from the beginning. She had stirred some hostile, slightly sadistic trend in him, and he had had the feeling he wouldn't let her put anything over on him. Because of this, he had been seeing only the hostility in her behavior. It was suggested that he try to think of how frightened she must be, and how, because of his attitude, she must feel she had no support from him. Maybe her behavior was a screaming cry for help. The analyst saw this and was able to change his attitude with unusually gratifying results. The patient soon stopped threatening and began to face her problems. It seemed clear that she felt at last that he wanted to help her. By seeing her as a little frightened child, and not his hysterical mother, he had lost his own fear of her, and with it his defensive hostility.

Not only do many crises in analysis arise from the unconscious emotional involvement of the analyst, but also many stalemates may be resolved by the analyst's study of his own reactions. The case of the patient with the loud scolding voice is one example. Another example is the following: A young analyst had a woman patient who acted out with great violence during the hour. She sometimes gave the analyst a push as she left the session. On one occasion she kicked him. At another time, she grabbed his hair. He remained impervious. To the best of his knowledge, he was being as an analyst should. In other words, he believed he was not supposed to get involved in the patient's emotional scenes. Undoubtedly, he was correct as long as his explosions were completely genuine. But nothing else was happening, and the frequency of the violent behavior was increasing. The supervisor got the impression that the patient was enjoying her little game, and suggested this to the young analyst. He was asked how he felt when he got his hair pulled and was kicked. He admitted it made him angry, but he thought he ought not to show it. He was advised to tell the patient he thought it unnecessary, that he didn't like it, and he thought it didn't help her. He did so at the next opportunity. The behavior stopped immediately. He found she had been reacting to his imperviousness. It was suggested that he try to think of how his imperviousness was being experienced acceptance and can, therefore, relate with his center (or core) reaction. The total personality of the analyst affects the total personality of the patient. Some of the attitudes may, at times, be countertransference or transference, to use Sullivan's term. In other words, they are based on irrational attitudes in the analyst developed in other circumstances, but, because he has had a long analysis, most of the personality is not irrational, and yet one analyst must of necessity differ from another.

Many types of people become analysts. Some are detached people, some have a slightly obsessional aura, some are highly imaginative, some impractical ivory tower types, others are very practical and down to earth, etc. Some are men, some are women and there are all variations of age from about thirty on. Also, especially in the United States, they vary greatly in their cultural backgrounds. There are Southerners, mid-Westerners, people from big Eastern cities, Europeans, first and second generation descendants of Europeans, and so on. When these are put into the mill of psychoanalytic training, it would be absurd to expect a uniform product. In fact, it would be disastrous if analysis could produce a uniform product, because it would mean that some of the essence of the personality had been destroyed.

In my early years as an analyst, I was taught the idea that any well-trained
so long in bringing up the subject. “Of course you don’t like it and you shouldn’t. But how can I trust you if you keep this feeling to yourself?” We then worked on the dynamics of his lying. It had originally developed as an attempt to play the clown in order to get some attention—for he was a neglected child. It came out chiefly in situations in which he felt inadequate. It proved to be not a basic dishonesty, but an attempt at socialization, and it disappeared under treatment. My insistence on the importance of honesty had blinded me to the fact that in this instance the dishonesty was analyzable.

We must relate to the patient with more than our intellects. We feel things that sometimes do not reach the level of verbal awareness. For example, why do I frequently yawn with a certain patient, why do I feel restless with another, and vaguely annoyed at times with a third? Is it simply the time of day or my state of weariness, or is there some more serious failure of communication? In the case of the yawning, I discovered in one case that it was especially frequent when a strong parasitic clinging tendency was predominant during the hour. We both found that this was a useful clue that the hour seemed to be getting nowhere, and that it actually was more effective in altering her attitude than a direct statement would have been. Undoubtedly, yawning can mean different things in different situations.

A persistent attitude of good will and genuine concern for his welfare will eventually reach through the patient’s distrust and despair. But—it must be genuine! A merely technically correct behavior is usually detected by the patient, if not consciously, then unconsciously. In short, an analyst must really like his fellow man in order to help him.

I once had a very hostile patient who had a diabolical ability to make his attacks effective by finding the most vulnerable spots in others. During a long and stormy analysis, in which he successfully hid bare all my weaknesses, I never became angry with him because I was sure that, basically, our relationship was sound, and that he trusted me as much as he was capable of trusting anyone, and that he had a genuine desire to understand himself.

Finally, I wish to bring up another aspect of the analyst’s personality that has its impact upon the patient, and that is the role of the analyst’s values in treatment. Herbert S. Spohn, Ph.D. has made an interesting survey of the influence of social values upon the clinical judgments of psychotherapists. He made a study of sixty-five therapists, twenty-nine of whom professed a Freudian orientation of varying degrees of orthodoxy, and twenty-six who professed a Sullivanian orientation. He does not mention the orientation of the other ten in the brief abstract I have seen. I believe the full report is not yet published. The area tested was the therapist’s criteria for mental health. His findings, in brief, were that in the Sullivanian or Frommian orientation group, there was a significantly greater tendency to reject the current entrepreneur values as the goal of therapy than was the case with the Freudian-oriented therapists. He speculated that while the greater explicit criticism of contemporary values of the first school played a role, he felt of greater interest was the fact that theoretical therapy orientations and personal social values are associated. That is—within limits—a therapist may choose his school of orientation according to his personal social values, and that his personal social values influence his goal for patients. I am sure the study does not intend to state that the therapist actively indoctrinates his own patients with his views, although that also has been known to happen, but it must influence, to some extent, the issues on which he places emphasis. In this way, his views are conveyed to the patient. Thus, it is not unimportant what a therapist thinks about many things, e.g. marriage, divorce, success, religion, politics—to mention a few obvious issues. His views are usually not stated, but their influence is implicit in his approach. For example, let us take the issue of divorce. If a therapist has a strong conviction that marriage should be maintained at all costs if possible, he will tend to ignore, consciously or unconsciously, or fail to encourage exploration of facts and feelings that would lead the patient to favor divorce.

Recently a young man patient of mine became very annoyed with me because I failed to show any interest in the relative prestige merits of cars. Since I do not own a car, myself, one could dismiss my attitude with the idea that I just don’t happen to be interested in cars. My first reaction to his remark was just that, but as I continued to think about it, I realized that I was also reacting to the man’s need for showy success. It was not one of my values, and I was indirectly conveying this idea to him by my lack of interest in his ambition to own a Cadillac.

Analysts who long for status and prestige invariably have trouble analyzing patients who have status and prestige needs. It is unnecessary to labor the point further, I think.

In conclusion, I would like to raise the question: Is there a type of personality in a therapist that will produce optimum results in patients? Psychoanalytic institutes have been trying for several years to determine this. Certain things are obvious. Freud’s first requirement was that an analyst must be a man of ethical integrity. He also needs to be relatively free of blind spots, and able to keep a flexible and open mind about himself. That is, he
must be a person who can sensitively interact with others and continue to learn about himself in that situation. He must have a genuine respect for others. A great variety of personality types can fulfill these requirements and the great variety is desirable because of the differing needs of different patients.

When it comes to a consideration of the relative merits of an analyst's values, there may be more divergence of opinion as to what type is best. I personally believe the patients' interests are best served by analysts who are not conformists—and certainly not blind conformists—but are always ready to seek new values in the interest of what is good for man. This, of course, puts me in the Sullivanian group. But the Sullivanian orientation did not make me a seeker after truth, no matter where it leads. It only gave me a greater opportunity to develop this aspect of myself. I found the school whose thinking and values approximated what I was seeking for myself.

Patients are not in such a fortunate position. They have less opportunity to know in advance the values of their prospective therapists. It has been established in hypnosis that it is difficult to get a hypnotized subject to do something contrary to his own wishes and values. Perhaps some failures in analysis are due to our attempts, wittingly or unwittingly, to force patients into a mold that they cannot accept. In this respect, an analyst's values are not unimportant for the outcome of the analysis.

NOTE
1. Some of the examples quoted have been worked out with the aid of a third person (supervisor), who could observe the total picture in a more detached way than the participants. It is my opinion that this is the most important function of a supervisor, especially after the basic principles of technique have become comfortable working tools. In fact, I think that small group discussion of problems about patients can be profitably used by analysts all of their lives. During the past few years, I have participated in a small seminar of graduates in which the emphasis is entirely on countertransference problems. It is a kind of miracle club, in which the participants swear the patient must have been listening in, because he reacts so often as predicted to the insight gained by the analyst. Should we not all subject this delicate, sensitive instrument—our own personality—to frequent overhauling? I do not mean necessarily extensive analysis, but checking on the spots where things are not going smoothly, especially with our patients. We do this as a matter of course with our cars, radios, microscopes—why not with the most delicate instrument of all—ourselves!