Chapter 2 The Psychoanalyst's Selfobject Needs and the Effect of Their Frustration on the Treatment: A New View of Countertransference

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We are aware of the multiple and complex definitions and conceptualizations of “countertransference” in the literature (see especially definitions and references in Rycroft, 1972; Moore and Fine, 1990) and we will not review them here. Historically, psychoanalysts have variously held two contradictory views on countertransference. One view is that it constitutes feelings on the part of the analyst that may interfere with the patient's therapy. The other is that it may be a valuable asset in the treatment process. Both these views of countertransference parallel, to a large extent, analysts' views of transference—that it may be an interference, a resistance, to the analysis and that it may serve as a major vehicle for the analytic process. Freud (1910) identified countertransference as an impediment to the effective treatment of the patient. This view persisted, for the most part, until 1950, when Heimann (1950) proffered a new definition and a novel perspective on countertransference. She regarded countertransference as comprising all the analyst's feelings.

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toward the patient, and she argued that the analyst's emotional response to his patient provided him with one of his most useful tools for understanding the patient's unconscious. Sandler (1976) extended Heimann's idea to include the process whereby the analyst becomes alerted to important experiences within the patient by becoming aware of certain roles that the patient induces within the analyst. This process repeats significant early relationships for the patient.

Because of the difference in the role of the analyst from that of the patient in the treatment process, the psychology of the analyst has been relatively neglected. If we agree with Sullivan (1953) that “everyone is much more simply human than otherwise” (p. 32), then as therapists we must surely assume that we are made of the same psychological stuff as our patients. That is, we therapists, too, bring a relational history, a cumulative representation of our lived experience of interaction to the analytic situation. This puts us in a psychological position not unlike that of our patients, despite the difference in our roles.

Kohut, interestingly, took a similar view to that of Freud when he described the “narcissistic” countertransferences as interfering with the establishment of the narcissistic transferences. Kohut (1971) understood how the analyst tends to react in particular ways to these transferences: “The analyst's own narcissistic needs ... may make it difficult for him to tolerate a situation in which he is reduced to the seemingly passive role of being a mirror of the patient's infantile narcissism, and he may, therefore, subtly or openly ... interfere with the establishment or the maintenance of the mirror transference” (p. 272). And “the rejection of the patient's idealizing attitudes is usually motivated by a defensive fending off of painful narcissistic tensions ... which are generated in the analyst when the repressed fantasies of his grandiose self become stimulated by the patient's idealization” (p. 262). Wolf (1979, 1980) and Kohler (1985) have elaborated on Kohut's views, using the new terminology of the “selfobject.” The selfobject transferences refer to the need of the patient for self-restorative and self-sustaining responses from the analyst. Wolf (1979) coined the term “selfobject countertransferences” to denote the counterpart in the analyst of the selfobject transferences of the analysand, whether or not they are evoked by the analysand. That is, the analyst, too, has selfobject needs that are mobilized as a result of participating in the analytic process (see Wolf, 1980).

Kohut's introduction of the new language was more than a change in terminology. It underscored his view that so-called narcissistic phenomena reflect the frustration and distortion of a basic sort of psychological need—indeed, a healthy need of the self in a relational context. As Kindler (1991) has explicitly stated in his fine paper on the subject, every individual has at his core a need to be mirrored or affirmed. However,

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while the analysand's needs for selfobject responsiveness from the analyst have become increasingly accepted as psychologically legitimate, the analyst's selfobject needs in relation to the analysand, although they are understandable, have in practice continued to be regarded as largely undesirable. They are unfortunate reactions from which the analyst should attempt to decenter. In other words,
we are still defining certain experiences of the analyst as "unhealthy." To put it plainly, the analyst should be ashamed of them. They constitute a problem that simply needs to be overcome. A large part of the problem is that analysts are, in effect, pretty good at disavowing their feelings when their selfobject needs are not met. We are not simply implying that "analysts are people, too" who have selfobject needs. We are, more importantly, also saying that because this is so it constitutes a very practical issue for the treatment of the patient. We have scarcely begun to explore the various ways in which the analyst's experience of his or her needs in relation to the patient and their satisfaction, frustration, or distortion affect the treatment process.

In this chapter, we will offer a new perspective on "countertransference." This perspective, in effect, supports the conceptual usefulness of restricting the usage of the term to refer to the interference with the analyst's therapeutic function. (This has, in fact, become the most common usage of the term.) We propose the view (see also Baezal, 1994) that the analyst's self is ordinarily sustained in his work by ongoing selfobject responses of the analysand, and we will argue that his or her analytic function may be substantially interfered with (i.e., countertransference reactions occur) when these selfobject needs are significantly frustrated. We will also suggest that the analyst's therapeutic function is enhanced as a result of his lessened requirement to protect himself or herself against the awareness of these needs. We will, further, suggest ways in which this goal may be attained—ways that centrally entail deactivating the sometimes disabling sense of shame that may accompany the awareness of our selfobject needs in relation to our patients.

We would affirm Wolf's view (1979) that, while we may have gained much from our personal analyses, none of us is entirely free from sensitivities, vulnerabilities, and longings that arise from personal and professional frustrations or injuries, both past and present. We plead for a measure of tolerance for the ubiquity of a wide range of inevitable shortcomings in the personalities of analysts. We do not of course condone the enactment by the analyst of selfobject needs or of any other needs in relation to the patient that are ethically unacceptable. When we speak of empathic failures or failures in optimal responsiveness, we are placing these against the background of the expectable performance of a committed therapist at the level of his or her experience and training. Having

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said this, we must acknowledge that all of us attempt to defend ourselves from the repetition of disruptive experiences and their disturbing affects—especially that of shame—with anyone, including with our patients.

Gunther (1976) emphasizes this perspective in his understanding of countertransference reactions. He sees them as enactments whose purpose is to restore the "narcissistic" equilibrium of the analyst that becomes disturbed in interactions with the analysand. They are symptoms of the reassessment of the analyst's narcissistic needs. Wolf (1980) was the first to explicitly recognize the bidirectional nature of selfobject neediness in the analytic process and to recognize its value and its liabilities as it is experienced by the analyst. Kohler (1985), on the basis of the work of Beebe and Slote, and Sander have described the complex interactions between the therapist's and the patient's selfobject needs as analogous to the interactions of the mother—child pair. Thomson (1991, 1993) has extensively illustrated how selfobject disruption in the analyst in relation to the analysand provides a particular opportunity to study how this may have contributed to the derailment in the patient. Baezal (1994) has recently suggested that

The therapist's experience of a selfobject relationship with the patient is not only pervasively operative in every therapeutic relationship but it constitutes a precondition for the therapist to respond in ways that will enable the patient to experience a selfobject relationship with him or her. Analysts regularly expect analysands to respond in a number of ways that are, in fact, self-sustaining or self-enhancing for the therapist [p. 28].

We submit that the complexity of these experiences requires conceptualization that the term "countertransference" simply does not do justice to at all. We believe that certain processes operating in the analyst that affect the patient may be usefully conceptualized in terms of the meeting of selfobject needs or the frustration of selfobject needs. We concur with Wolf that the term "empathic resonance" usefully describes the situation when the analyst effectively undergoes a controlled regression along with the patient in his efforts to remain attuned to him. However, to regard this as an aspect of countertransference—a term that commonly designates an interference with the therapeutic process—is conceptually confusing. This limited regression is in the service of the therapeutic relationship. Our understanding of empathic resonance is similar to Balint's understanding of the harmoniously regressive archaic experience which he termed "primary love" or "primary object-love" (1937, 1968) as it occurs within the analytic dyad—an experience not

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dissimilar to Kohut's conception of the archaic selfobject twinship transference.¹ A basic sort of alterego selfobject relatedness² is mobilized in the analyst (I know how you feel because I have had, or am having, similar experiences of my own). In this regression,
the analyst may also have a complementary experience to the patient's selfobject experience (I sense your need, for example, to be special, and I do experience you in that way). Thus, in exercising his or her capacity for vicarious introspection, the analyst may experience comparable or complementary needs of his or her own being met by the patient. We would add, parenthetically, that the need to give that is activated in the analyst—for example, to respond to the selfobject need of his analysand—may be one of the deepest and most vitalizing needs of his self (cf. Ian Suttie, Chapter 1 in Bacal and Newman [1990], pp. 19-20).

In her recent study of the subjective and intersubjective determinants of optimal responsiveness (see Bacal, 1985), Estrella (1993) noted that the mutuality of subjective experiences contributes significantly to therapists' attunement and empathic resonance. She found that “the psychotherapist's attunement to his or her own subjective pain and corresponding resonance to their particular patient's pain may have contributed significantly to their being optimally responsive,” especially around instances of loss. We do not think that experiences such as these are properly included in the idea of “countertransference.”

Wolf (1980) has suggested that the analyst's experience of the intensification of his selfobject needs may be used as signals to alert him to an impending derailment of the therapeutic process. We would propose the term “signal disruption in the analyst” to denote the analyst's experience of his selfobject needs are not being met, but when his self maintains its stability and cohesiveness. When the analyst has what we traditionally call a countertransference reaction, the analyst's selfobject needs that are ordinarily being met by the patient during their interaction are now being frustrated, and his sense of self is concomitantly threatened or shaken—or worse. This selfobject disruption in the analyst will affect the analyst's capacity to attune and to respond optimally to the patient. If analysts insist on retaining the term “countertransference” (which they probably will do), we believe that it should refer to these reactive or

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1 Balint's concept of primary love is similar but not identical to Kohut's archaic merger transference. In the archaic merger transference, the other is experienced as part of the self. Primary love does not necessarily entail a loss of boundary; rather, the object is experienced as having similar or complementary needs as the subject (e.g., the baby experiences her need to feed and be held as identical or complementary to the mother's need to feed or hold the baby).

2 Basch (1992) regards the alterego, or twinship selfobject experience, to be basic to human relationships.

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disjunctive phenomena that affect the analyst's therapeutic function. These run “counter,” if you like, to the selfobject “transference” needs of the analysand in the treatment.

It must be emphasized that the therapist's selfobject needs do differ from those of the patient insofar as they are represented through his or her therapeutic function. The most common selfobject need of the therapist is for mirroring of his function according to whatsoever way he conceives this function. If he conceives it as a caring attitude, he needs to be affirmed for this. If he conceives his function in terms of cognitive understanding, he needs affirmation for this. If, for example, he needs to idealize the patient, then he can feel wonderful if he perceives his patient as having special attributes. He may see his function as providing a holding, enlivening, reliably receptive ambience, for which he unconsciously needs affirmation. In the course of the analysis many of these needs are ordinarily met by the patient's attendance, his arriving and leaving on time, lying on the couch while he is there, staying awake, supplying associative material, listening to interpretations, paying a fee, picking up the tab for missed sessions, and so on—that is, conforming, more or less, to the routines of the analytic situation. In this situation, the analyst is usually no more aware that these routines may embody selfobject needs than he is of the air he breathes. To some extent, the analyst's training makes him take the meeting of these expectations for granted.

In his training of general practitioners for psychotherapeutic work, Balint (1964) referred to the “apostolic mission or function” of the doctor—“that every doctor has a vague, but almost unshakably firm, idea of how a patient ought to behave when ill.... It was ... as if he had a sacred duty to convert to his faith all the ignorant and unbelieving among his patients.” Balint added: “Although this idea is anything but explicit and concrete, it is immensely powerful, and influences ... practically every detail of the doctor's work” (p. 216). We believe that these expectations derive not only from therapist's training—some may say, from his or her indoctrination—but also from the therapist's unmet selfobject needs that he brings to the patient in the therapy situation. Personal analysis may enable the therapist to engage some of these needs, but unless they are addressed more directly (as we shall discuss in a moment), they may remain largely unconscious and thus pose a potential

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3 Countertransference reactions that involve the analyst's needs may also be conjunctive (or “collusive”). This may occur when the analyst tacitly—or even explicitly—encourages the patient to hope for the fulfillment—or enactment of—unmet needs of the analyst that correspond to those of the patient. In these instances (which are often unconsciously motivated), the analyst may sometimes find himself offering more than he can deliver. These reactions may thus also run counter to the therapeutic needs of the patient.
interference with the therapist's efficacy. Therapists' enhanced awareness of how their psychological needs and vulnerabilities have become organized into their professional working persona will enable them to become clearer about the limits to their capacity for optimal responsiveness to any particular patient.

Perhaps the therapist's predominant need is for affirmation of his capacity to understand and, in many instances, for his caring, humanistic motivation. We suspect that this need by therapists to be seen as decent, well-motivated human beings in their work is both pervasive and unacknowledged; yet it is difficult for analysts when they are thought to be anything but that by their patients. This need may reflect an inadequate working through of the "darker" or "nastier" sides of the analyst in his own analysis. Conversely, an analytic experience in which the dark side was all too vigorously attended to may repeat a trauma of the therapist's childhood. These experiences may leave the therapist with significant unmet needs that he or she brings into the consulting room. For some therapists, the meeting of such needs is at the center of their general raison d'être. The therapeutic work with their patients may serve to repair defects in self-structure that arose from a requirement to accede to the archaic selfobject needs of their caretakers. The self-esteem and self- cohesion of these therapists will depend on their success in fulfilling the needs of their analysands (see Stolorow and Atwood, 1992).

When a patient becomes seriously disrupted, the analyst's selfobject needs may become significantly frustrated; in particular, the analyst may experience a loss of the sense of efficacy. He may also experience dysphoric affects such as anger, inadequacy, disappointment in himself, and shame.

Clinical Illustration: Tina

A situation that illustrates a number of these issues arose with Tina, an accomplished and successful young architect. Tina had a mother who was continually and grossly out of tune with her affiliative-attachment needs, and who had been so, apparently, from Tina's early infancy. In her analysis, Tina railed bitterly, angrily, and despairingly against her mother's insensitivity, cruelty, and her near-total dismissal of the validity of her daughter's complaints. As she regressed in the transference, which was largely positive in an idealizing way, she began to experience the holiday breaks as quite intolerable. And on more than one occasion, she experienced herself dissociating and fragmenting during breaks in

4 This requirement corresponds to the vertical split situation described by Kohut (1977) and to the false self reaction described by Winnicott (1968; see also Baez and Newman, 1990).

ways that profoundly distressed her. However, she never appeared ill enough to justify hospitalization, nor was she at all interested in taking medication. The analyst responded by offering what he regarded as appropriate transference interpretations—essentially that she experienced him as repeating the neglect of her mother and deserting her as her mother and others had done in the past. Tina did not contest these interpretations, but they were of no help in relieving her painful symptoms.

As time went on, and each break produced the same horrendous distress, Tina began not only to rebuke the analyst for leaving on his holiday, but to imply that he should not be going, because of what it did to her. The analyst experienced a conscious resistance within himself to accepting the validity of his patient's request, that is, that the only way that he felt he could remedy the situation was never to take a holiday. He needed to feel that, despite her dissatisfaction, he was being a good therapist for Tina and he also needed to feel free to take a holiday. In other words, selfobject needs of the analyst that Tina had easily met all along and of which the analyst had been quite unaware, were now being significantly frustrated. It should be mentioned that Tina never appeared to want to go on holiday with the analyst—in which case he would have had more problems—and she was quite uninterested in phoning him as a substitute for his being with her.

The analyst eventually stopped attempting to explain (i.e., to interpret) the reasons for Tina's self-disruption during breaks, because he thought that she had gone off the deep end around this issue and that it was time to draw her attention to the "reality" of the situation—that it was quite unrealistic of her to expect him not to go on holiday, and that he would simply not entertain the idea seriously. This did not help either. The analyst was now torn between a sense of outrage and a sense of inadequacy, shame, and guilt. He was angry that the patient would deprive him of his right to something that was important and necessary to him, and that in doing so she was being outrageously excessive in her demands. He also felt inadequate as a therapist—nothing he could say was useful and his patient was, by her account, made worse by the analysis and regarded him as a bad, cruel, and uncaring person. He liked and
admired Tina, and generally felt good about his ongoing work with her. He did not, however, know what to do to remedy the situation as she experienced it. Tina left the analysis after four years but returned some months later for psychotherapy because she felt unable to hold onto a man. She consciously decided to avoid the regressive experience of analysis that would render her vulnerable to trauma at holiday breaks, but she referred, reproachfully, to the “failed” analysis—which failed, as she saw it, because of the analyst’s inadequacies.

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Indeed, it would take several years more for the analyst to “get it,” an achievement that, as Wolf (1980) has conveyed, would come from the growing strength and therefore decreasing vulnerability and neediness of the analyst’s self. The analyst had to be able to accept that his responses were not good enough for the patient without experiencing a disabling sense of shame. Paradoxically, of course, this acceptance made him a better analyst for Tina.

It is useful to discover—to really discover—that one’s selfobject need to be recognized by the patient as a good-enough therapist is common to all therapists, and that this need never completely disappears. This therapist’s recognition and acceptance of the need enabled him to begin to provide Tina with what she really needed from him—the deep-going validation that she had been right all along, that he was insensitive to her needs and therefore was cruel to her. He placed his need for a holiday above her pain and he deserted her, like all the men in her life and like her mother, too. She was right—he didn’t care about her all that much. She was, as she put it, “only” a patient, and he was “only” an analyst. She didn’t need to experience his blame or his shame or his guilt. In taking his holiday, he had made the choice, at that moment, to put the needs of his self before those of Tina’s. In other words, when she reproached him, all he had to do was to say “uh huh” and mean it, and she felt understood. Following this acknowledgment, Tina’s reproaches to the analyst for his unresponsiveness to her suffering when he went on holidays did not recur.

When the selfobject needs and expectations of the analyst are met by the analysand, a situation of mutual regulation—a kind of harmony, as we have described it—prevails in the analytic ambience. At these times, the analyst may feel a variety of self-syntonic emotions, such as friendliness, concern, mild idealization, sympathy, compassion, and also sometimes anger or attraction of a regulatable degree toward the patient. However, when, for whatever reason, the analyst’s needs are not met, he may experience the painful and even visceral sensations of disrupted self-states that can undermine his therapeutic function. These disruptions include distancing, disinterest, hostility and hatred, contempt, eroticism, prolonged boredom, sleepiness, or even falling asleep.

In the following example, the analyst experienced frustration of his need to feel that he had a function as a therapist. He was also frustrated in his need to experience himself as supplying care for the patient.

**Clinical Example: Sarah**

For many months, Sarah, a young woman analysand, repeatedly asserted, often vehemently, that there was no relationship and that the

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analysis was meaningless. Despite this she attended regularly. The analyst reacted to Sarah’s assertion by interpreting it as a resistance to transference. He repeatedly told her that she was avoiding her feelings and needs regarding the therapist. The only effect of this was that the patient reasserted, with even more passion and distress, that there was no relationship. She became disillusioned with the analysis and indeed with life itself. At one point, she cried, “Analysis is totally useless. Why do you let me come? It’s a big sadistic tease.” One day, in great despair, Sarah left a message on the analyst’s answering machine telling him the analysis was hopeless and she would not be returning. Galvanized into action by fears of the patient’s committing suicide, as she had attempted to do several times in the past, the analyst contacted her and was able to arrange an emergency double session. The analyst now began to sense that he had not been attuned to his patient’s aversive state, and that he must set aside his preoccupation with defenses against transference. For the first hour or so, Sarah expressed her desperate and disillusioned state with great affective intensity. Then, perhaps sensing, via the analyst’s murmurs of assent, that he was more attuned, she became calmer. She then spoke with much emotional pain of her father’s unavailability. She recalled climbing up onto his lap as a small child only to experience him as “a hard wooden chair.”

As the session drew to a close, she spoke of her former therapist in the following words: “I did not meet his needs. He needed to do good. He needed to have an impact.” The therapist almost immediately recognized that these comments also referred to himself and fit well with his attitude of the previous few months. He now recognized that his argumentative interpretive activity, rationalized as theoretically sound, had masked a frustrated selfobject need—a “countertransference reaction,” if you like. During that period he had
had to avoid awareness of his need to have a function, to be an "analytic somebody." He had thus failed to attune himself to his patient's need to work through, in transference, a repetition of her aversive experience of an unresponsive and unavailable father.

In the vignette just described, the analyst attempted to satisfy his need for efficacy by repeated interpretations of his patient's need to deny her transference feelings toward him. Interpretation has been accorded such a high and unquestioned value in analytic practice that we have lost sight of—or perhaps never saw—how intrinsic it is to the analyst's assertion of his role as an analyst. A little self-analysis will demonstrate that

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5 According to Wolf (1988), "Efficacy need is a person's need to experience the self as an effective agent, that is, capable of eliciting a selfobject response" (p. 181).

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most of us tend, at times, to step up our interpretive activity when we feel less effective with our analysand. We may then interpret simply to assure ourselves that we have a function. As training analysts, we often urge our students to make interpretations, especially transference interpretations. We believe that transference interpretations are not infrequently offered when the analyst feels unengaged with the patient. In one such instance, the analyst found himself drifting off during a patient's silence. He then experienced the urge to interpret that the patient was removing himself from the analyst and was thus making it difficult for the analyst to stay with him. Fortunately, the analyst was able to recognize that his own needs for stimulation and a sense of functioning were at odds with the patient's need to use him through silence, and that he would only experience the interpretation as the analyst's need for the patient to accommodate to him.

We are all familiar with the patient who continues to associate, apparently doing his own analysis, but who leaves the analyst out of his associations for long periods. Such a patient will not only tend to make the analyst sleepy (McLaughlin, 1975; Dender, 1993) but will also tend to elicit transference interpretations, or interpretations about his or her resistance to transference. In our view, these interpretations are motivated unconsciously by a specific deprivation in mirroring: a depletion has occurred in the analyst's experience of being recognized, of being seen. The significance and utility of his existence as an analyst are simply not acknowledged. An ongoing selfobject need the analyst has generally come to count on his patient to meet is no longer being provided and the analyst feels useless and devitalized. The analyst then interprets in order to bring himself forward and center. Although some patients may be able to shrug off such interpretations as simply incorrect, others may experience them as a disruptive transference repetition of the intrusive archaic selfobject needs of a significant caretaker.

Clinical Illustration: Tom

Tom, a young psychologist in analysis, regularly talked on without pause and without any reference to the analyst. Tom clearly liked and admired his analyst, and the analyst quite liked Tom, who was upbeat and who struggled bravely and insightfully with the many problems in his personal relationships. The analyst, however, usually felt so bored and sleepy he could hardly stay awake. He rarely had the opportunity to make an interpretation; in any event, it did not appear necessary to do so, as Tom articulated everything the analyst regarded as relevant. In short, the analyst felt unengaged and irrelevant to Tom's therapeutic experience. However, Tom idealized the analyst's skills, and he would, from time to time, refer to "our relationship," which, he implied, he valued very much.

Whereas the analyst felt he needed to give some interpretations in order to be useful, the analysand admired the analyst's capacity (as the analysand experienced it) to appreciate his ability to understand himself. What no doubt helped the analyst to avoid interpretations (that is, confrontations) that the analysand was "resisting" the transference was that the patient was improving steadily, which provided him with a sense of satisfaction, if not a sense of efficacy. When he did, on rare occasions, offer such interpretations, the patient seemed to shrug them off: they were neither useful nor disruptive.

Late in his life, Winnicott (1971) came to the conclusion that he had often prevented or delayed deep change in his patients by his need to interpret. And Casement (1985) states: "I was often tempted to interpret just to reassure myself that I was still able to think and to function in the session, when things seemed chaotic, but I had to learn to refrain" (p. 177). We would add here that when the analyst reassures a patient, his underlying need is sometimes actually to reassure himself.

We have referred to the significance of shame in the therapist's experience of frustration and disruption of self-cohesion, and in
particular to the difficulties in facing shame. Here is a vignette that illustrates this vividly.

Dr. S sought her analyst’s help in connection with a distressing reaction she had to a psychotherapy patient who had been recurrently talking about discontinuing treatment. Dr. S had responded to her patient’s talk of terminating his recently begun, once-weekly therapy sessions by telling him that, in her view, he should not only not quit but that he should come five times a week. Immediately after saying this, she felt suffused with an inexplicable sense of intense shame. There is no question that her shame was partially in reaction to her sudden awareness of what she had done. That is, asking her patient to do something that she realized he was quite unprepared to do made her feel foolish both to him and to herself—and to her analyst, when she reported it to him. She was also understandably reluctant at first to permit the analyst to include the vignette in this chapter, because, like most therapists, she did not quite believe that everyone, including her analyst, had had the same kinds of experience. There was more to understand, though.

Dr. S’s patient had been suffering keenly as a result of the recent abandonment by his wife. His wife had begun an affair with her husband’s boss and had moved in with him along with the patient’s three children. The patient was trying now, with considerable difficulty, to live a new life on his own while continuing in his role as father on a part-time basis. Dr. S had been empathically resonating with his strongly disavowed

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—and intense—feelings of shame about his wife’s abandonment. Dr. S had had similar feelings in comparable circumstances—some of which she had never completely owned. Dr. S was not new to experiences of abandonment. Prominent among them was the loss of her father—to whom she had believed she was special—who left home when she was a little girl. In addition, she was currently facing the painful possibility of losing her boyfriend. Her patient’s talk of leaving stirred up disavowed feelings of shame associated with her experiences of abandonment. She could empathize with her patient and respond optimally to him as long as he did not do the same thing to her that others had done—and what his wife had done to him. When her patient announced his intention to leave her, she lost her empathic resonance with him because she had in part unconsciously apprehended him as the selfobject who must not desert her. The shame surfaced when she tried to get him to be with her even more frequently. She was, in effect, expressing her unconscious, unrequited love to her abandoning father, whose leaving she had been powerless to prevent.

Dr. S also came to see that her disavowed sense of shame, and that of her patient, was due to a feeling of inadequacy. Neither of them had felt able to maintain their regard for their idealized partners who had failed them (for the patient, this was his therapist, his wife, and his family; for the therapist, it was her patient, her boyfriend, and her father) and, in consequence, they were unable to retain their sense of self-respect. The commitment of her patient to the therapy unconsciously represented (that is, symbolized) for the therapist the partial but significant redressment of a lifelong disillusionment in an idealizing need and that of a mirroring need to be special again. The therapist had made herself vulnerable to shame because she needed to disavow her selfobject needs in relation to her patient. Had she been able to understand and accept them, she would likely have been able to offer her patient a considered therapeutic response instead of reacting to the “signal disruption” that his talk of leaving elicited.

This therapist’s experience is not unique. Variations of her story about the significance and meaning of the relationship with her patient are common currency among therapists. We would claim that the patient’s commitment to the treatment meets a universal idealizing selfobject need of therapists and a universal need of therapists to be mirrored as being effective and special to their patients.6

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6 The patient’s commitment to the treatment likely also meets the need for attachment to a significant other—a need (that is in many ways similar to the need for selfobjects [see Baceal and Newman, 1999]).

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Thus, the situation for the analyst is essentially the same as it is for the analysand; If the analyst cannot accept the psychological legitimacy of her selfobject needs in relation to the patient; she will be affected in the same kinds of ways as the patient, her needs will intensify and she may act them out, very likely in relation to the partner who has frustrated them—her patient. If we must protect ourselves from the shameful awareness of our needs in relation to our patients, we will not be able to resonate empathically or respond optimally to their comparable, disavowed needs. If, however, the analyst can accept the psychological legitimacy of these needs, it will significantly enhance his therapeutic function (see Baceal and Newman, 1990; Baceal, 1994). This is, in effect, what happened when Dr. S worked this through in this way with her analyst. In other words, when her sense of shame about these needs and expectations in relation to her patient decreased, her defenses against them also relaxed; as a result, she could then extend the same empathy and acceptance to both herself and her patient.7

We believe that it is only recently, in particular because of the work of Broucek (1991), Morrison (1989, 1992), and Wurmser
(1981), that the ubiquity of shame in human experience is becoming recognized. The therapist is no less liable to experiences of shame and to those defenses against shame experience that Morrison has described. But these experiences also offer us the opportunity for fresh self-inquiry, self-understanding, and self-acceptance. There are a variety of ways of pursuing this. "More analysis" is often the prescription for such problems, and it can help. Formal consultation or supervision is another. These tasks can also be very effectively accomplished if the therapist's analyst is prepared to respond directly to the therapist's discussion of his or her therapeutic work during the analytic sessions. In this way, the analyst can offer his immediate understanding of his analysand's countertransference reactions as they relate to the frustration of her selfobject needs in the work with her patient. This, in effect, characterized the way that Dr. S's training analyst worked with her, a method of supervision that was regularly offered by Ferenczi, Balint, and others to trainees at the Budapest Institute of Psychoanalysis.

7 Gunther (1976) recommends that the analyst use "selective empathy" with himself as a means of monitoring his defenses and disturbances. Gunther's emphasis is on the expectable "narcissistic" difficulties that analysts will encounter when doing analytic work. We affirm his observations; our additional emphasis, however, is upon the ongoing selfobject functions that are ordinarily supplied by the analysand to the analyst, and the effects of their frustration.

8 In Hungary, at the Budapest Psychoanalytic Institute, this was the usual form of supervision. When Balint emigrated to England from Hungary in the late 1930s, he offered this form of supervision to his trainee analysands at the British Institute of Psychoanalysis. He supervised the student's first training case during the student's own analytic hours. In this way, the student's countertransference problems could be addressed with more immediateness, richness, and effectiveness than in the standard form of supervision, where the unconscious determinants of the student's countertransference can only be touched on by the supervisor. Dr. S was, in fact, worked with in this way.

Another effective approach is to seek out opportunities for open exchange with trusted colleagues. The exploring and sharing, in a collegial ambience, of experiences about the effects of frustration of our selfobject needs and disruptive states can be enormously useful. We regularly find that, as a result of these exchanges, we have less propensity to feel ashamed of our "failures"; at least, shameful feelings do not inhibit our self-inquiry. In effect, the discovery that these experiences are indeed universal appears to be especially helpful in enabling therapists to become freer to respond optimally to their patients. These discussions can be undertaken with especial effectiveness in groups of therapists—for instance, in the so-called Balint-type groups, whose ambience facilitates the forthright engagement of problematic intersubjective issues (or "countertransference" problems). In this situation, the discrepancy between the faulty therapist and the supposedly nonfaulty therapist is greatly diminished. In addition, the evolving bond of trust between members mitigates the shame of disclosing one's selfobject needs and the defenses against them. Concomitant with such a process, one's self undergoes significant strengthening.

There are some difficult or adversarial situations, however, that may particularly strain an analyst's capacity to maintain an empathic stance and benign bond with his patient. As one of us (H.B., in Bacal and Newman, 1990) has observed:

[When ... certain of the analyst's selfobject needs surface and he perceives his patient as, so to say, "violating" his expectations or acting upon him beyond the threshold of his tolerance, [t]his may precipitate a reaction in the therapist that can trigger or exacerbate a disruption of the patient's sense of selfobject relatedness to him [p. 269].]

Such situations, when the patient becomes disrupted and perhaps enraged, may reverberate back onto the analyst, resulting in further frustration of his psychologically legitimate needs for self-enhancing or self-restorative responses from his patient. Now the analyst may experience a spectrum of painful feelings such as rage, hatred, anxiety, profound discouragement, and loss of self-esteem. He also experiences the pressure of the requirement that he decelerate from such feelings in order to remain in empathic contact with the patient. This, however, may be easier said than done, for it may seem to him that it demands that he totally disavow authentic aspects of his affective experience. We may ask whether self psychology demands too much of the analyst by

[In order to achieve his objectives the analyst must forfeit his personal needs to the maximum degree possible, so that he can place himself or herself in the service of his patient and his science.]

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I believe such demands are unrealistic and unwarranted. They place the analyst in the defensive position of claiming altruistic motives he usually questions in others and of disclaiming in himself the very needs he helps his patients to acknowledge and satisfy [p. 343].

Is it not the analyst's natural and perfectly human need to protest against the assault on his own sense of self? No doubt in the vast majority of instances such protest would not be expressed openly. But the right to give covert—and sometimes even overt—expression to his own aversive attitude may help protect the analyst from injury and, having acknowledged his legitimate needs, enable him to continue working with his patient.

For a long period in the analysis of a young woman, every interpretation the analyst made disrupted her. She angrily and contemptuously dismissed almost all his interventions. The analyst now, himself, became disrupted. He began to experience increasing degrees of mortification, shame, and disappointment in himself. He strove valiantly to restore both the patient's and his own self-esteem by searching for the "right" interpretation. This was all to no avail. Finally he withdrew in discouraged silence. As his own vitality and cohesion were undermined, so did this reverberate on the patient in a vicious circle. This analyst was unable to accord himself the right to protest, even inwardly, at the patient's failure to affirm him. It was only with the aid of a consultant that he was able to begin to tolerate her disillusionment. The problem of this analyst with this patient is one that might especially lend itself to the kind of group discussion and support that we have suggested.

Winnicott (1947) recognizes that the analyst will, at times, hate the patient, especially the regressed patient (p. 195). He regards it as important that the analyst acknowledge this hate to himself and tolerate both the patient's hate and his ingratitude. Winnicott is, in effect, implying a significant selfobject need on the part of the analyst that is being deeply frustrated by the patient. In our experience, if the analyst accommodates to the analysand on a continuous basis in order to avoid the patient's experiencing intolerable trauma in the transference, the hate engendered in the analyst by the prolonged frustration of his selfobject needs will inevitably interfere at times with the analyst's therapeutic function.

We recognize that not all analysts find adversarial situations difficult or disaffirming. In fact, some analysts feel mirrored or stimulated by the cut and thrust of an aversive encounter, as do some patients. The different personalities and theoretical approaches of analysts indicate great variation in their selfobject needs and expectations. The number of permutations and combinations in mutual selfobject needs, and frustrations of such needs, in the psychoanalytic situation must be infinite.

Stolorow and Atwood (1992) emphasize that sustained empathic inquiry must include the therapist's continual reflection on his ongoing subjective processes (i.e., as part of the intersubjective field). We believe it should be possible for an analyst to become practiced in monitoring his self states as they are affected by those of the patient and by the effects of external factors on his life.

We have argued that the analyst's self states are significantly affected by his selfobject experience in relation to the patient. In other words, what enables the analyst to carry out his therapeutic task—what, so to speak, keeps the analyst going—centrally includes responses on the part of the analysand that provide the analyst with selfobject experience. The recognition that it is psychologically legitimate for the therapist to have these needs and that their frustration contributes to countertransference reactions will not only alter our conceptualizations of the therapeutic process but will also enhance our capacity to respond optimally to our patients.

References

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9 We are referring here to trauma that tends to occur when the analysand regresses to pathognomonic, genetically related disruptions in the transference—what Balint called "the basic fault" (Balint, 1968; Bacal and Newman, 1990).

10 Lessem and Orange (1992) suggest that the mutuality of selfobject experience is associated with an increasingly solid bond of seeker and healer. That is, the therapeutic process is enhanced by the patient and analyst both experiencing the other as providing selfobject functions.

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