Experience and Insight in The Resolution of Transferences

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Reprinted from

CONTEMPORARY PSYCHOANALYSIS

Volume 27, Number 2 April 1991

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I AM HONORED TO PARTICIPATE in a symposium sponsored by this Institute, which has a proud tradition of independent thought, and a longstanding commitment to the study of processes taking place between patient and analyst. I have shared some of that same commitment myself since first reading Harry Stack Sullivan during graduate school. In this spirit, I shall focus today on the role of immediate experiences between patient and analyst in resolving unconscious transferences.

I shall present clinical vignettes which show that analytic patients may become conscious of a previously unconscious transference, and may make progress toward resolving this transference, without interpretation. The vignettes are not intended to minimize the importance of interpretation; I believe that precise interpretations are a crucial aspect of analytic work. Instead, the vignettes cast light on another crucial feature of analytic work. They show that actual experiences in the relationship between patient and analyst, even without interpretation, may correct pathogenic transference expectancies, and enable the patient to begin to resolve an unconscious transference. They also show how patients themselves work unconsciously to solve their psychological problems. Moreover, the vignettes give us some indication of the lawfulness of the relation between experiencing and gaining insight.

Ms. Y.

My first vignette is from the case of Ms. Y., a divorced professional woman who had had three previous analyses of 6 years, 9 years, and 3 years respectively. In addition, her behavior had been carefully observed and regularly interpreted from the cradle onward by her hovering father, a successful businessman, who kept a daily diary of his only child for several years. A typical entry from

0010-7530/91 $2.00 + .05
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Contemporary Psychoanalysis, Vol. 27, No. 2 (1991)

Ms. Y.'s third year of life noted her behavior around two older children: Ms. Y. was timid; she lacked self-confidence and self-respect; she cried when her toy was taken away. He spoke to her about her difficulties. A later entry expressed his concern about disobedience and defiance. He pointed out these problems to her, explained her covert hostile motivations, and was chagrined at her attempt to deny responsibility—which he also pointed out to her.

In her early 20's, Ms. Y. entered analysis to discover what was wrong with her. In the course of her 3 analyses she learned a great deal about her narcissism, hostility, and infantile sexual impulses; but she did not improve.

In early hours with me she described several interactions with her now adult children. She saw behind the surface of whatever they said or did, discerning hidden hostilities, hidden sexual impulses, and low self-esteem. She informed them regularly about these tendencies, but they showed little appreciation of her help.

I decided to take a different tack with her. Thus, although she was late for most sessions for the first several months, I did not comment on it or investigate it. If she offered some possible hostile motive for her lateness, I did not bite the exposed jugular. One day she arrived 20 minutes late and asked me if I was angry at her. I said no. She was silent, then said: I wonder why I expected you to be furious. Absolutely furious. After another silence, she said that her father couldn't stand her to keep him waiting even a moment. No excuse was acceptable to him. He would be furious, and often struck her. After another pause, she said: it's funny, you're the first therapist who ever answered when I asked if they were angry. I've been told that answering such a question would keep me from becoming aware of my own thoughts and feelings. It doesn't seem to have worked that way.

Mrs. W.

My second vignette is from the case of Mrs. W., who was analyzed by a colleague. Mrs. W. was a 33-year-old highly successful lawyer who seemed unusually conscientious in analysis as in life. She was always helpful toward friends and associates, and unconsciously felt responsible for solving their problems. She sought analysis because, in spite of business success and a good marriage, she felt driven, derived little pleasure from anything, and now and again felt vaguely depressed. This feeling did not interfere with

her functioning, but it made her aware of how dissatisfied she felt. In childhood, Mrs. W. had developed an unconscious belief that she was responsible for making her chronically dissatisfied mother happy. She worked hard to do so, but did not succeed. She had unconsciously inferred that she was not doing enough for mother.

Mrs. W.'s initial manner in analysis was relentlessly earnest, hard-working, almost grim. She was completely task-oriented. She focussed determinedly on problems confronting her, and her feelings and ideas about them, but she continued to feel dissatisfaction. She implied from time to time that the analyst was not doing enough, or not doing the right thing, but she denied any interpretations that she had such feelings.

The analyst noticed that he had adopted, without premeditation, an unusually chatty, informal style with Ms. Y. He talked in an unhurried manner. His interpretations were casual and a bit lengthy. Sometimes he digressed from the immediate task, or joked a little. After a few months, he noticed a change in the patient's behavior. She began sessions with a few comments about the weather, the traffic, politics, even football. The analyst responded conversationally, and they would chat for 10 minutes or so. The patient then shifted back to her earnest, dissatisfied manner. The analyst offered interpretations freely and she worked on them diligently but without any sense of pleasure or progress.

One day she began in her now customary way with chatty items of the day and then said: Ever since I began to work—or before, even in law school—I've worked through my lunch hour without a break. Yesterday, I went out to lunch with a friend, and I enjoyed it. I thought to myself: you (i.e. the analyst) don't seem to work too hard here. You seem to be enjoying yourself. There was a long pause, then: You don't seem to feel responsible for my problems and dissatisfactions to the same extent I do with my friends' problems. I wonder why I have to be so driven, so responsible.

In the following sessions, she became both more relaxed and more productive. She became aware that she had felt critical of the analyst during the first few months for not working harder and taking more responsibility for her unhappiness. But what surprised her was a different reaction: she had also felt relief when he continued to work in an easy, relaxed way, offering interpretations without a feeling of urgency, or pressure to satisfy her. She also began to remember more about how dissatisfied her mother had

always seemed. She became conscious of a childhood feeling of desperate urgency to make her mother happy, and of how she always felt she should be trying harder. She realized that she has that same feeling now toward her husband, her friends, and her business associates.

In this vignette, the analyst's demonstration of a relaxed attitude, of a sense that he was not irrationally responsible for making her feel satisfied, began to disconfirm her unconscious belief that she was responsible for making her chronically dissatisfied mother happy. This enabled her to feel a little less irrationally responsible and driven. She became able to go out to lunch with friends and to enjoy herself. She also began to make conscious and to resolve an important aspect of her transferences to the analyst.

Mr. A.

My final vignette is from the case of Mr. A.

Mr. A. was a 35 year old, financially successful entrepreneur who was referred to me by a colleague who was also a close friend of Mr. A. My colleague told me that Mr. A. was a womanizer, but had no successful long term relations with women. He could be difficult interpersonally: rude, blunt, irritating, and often abrupt and rejecting. He was brash. He never heard what others said to him, and he interrupted conversations. He could be obnoxious. Nonetheless, my colleague said that he genuinely liked Mr. A., and he did need help.

I was returning to my office a few minutes before my first appointment with Mr. A., and as I was about to close my door he rushed up to me: Hal, he said, don't shut the door on me.

I'm Fred A. I have an appointment with you.

He told me he wanted help with his inability to make a commitment to a woman. And his mother was driving him crazy. He then characterized himself in almost identical terms to those used by my colleague, but added that he was completely insensitive to the feelings of others. Moreover, he said that he had no access to his own feelings and no understanding of his own psychology or that of others.

Over the first months, Mr. A. characterized my comments and interpretations as ridiculous and useless. For example, he would invite comment about his behavior, and if I offered anything would say: This is the stupidest idea I've ever heard. In addition,

he could not remember what either of us said from one session to the next, and he attributed this to his complete lack of interest in feelings or relationships. My general approach, in spite of his provocativeness, was to be serious myself about our work, and to treat him seriously.

The specific vignette I shall describe bean after many months, and it began as a self-observation. I recognized that in the past few hours I had been feeling confused, that I could not recall what we had been talking about, and that I felt disconnected from him and uncharacteristically discouraged. Over the next sessions I began to observe how my feelings of confusion began. I noticed a typical sequence that went something like this: The patient talked about topic A for several minutes. I expressed interest, maybe asked a question. He responded in a sentence or two, then changed the subject to topic B, which lent itself to interpretation of a problem we had begun to identify. I interpreted. The patient, often without any acknowledgment of my interpretation, switched to topic C. He said something serious, reflective, and insightful about it. I picked up that topic. He switched immediately to topic D, which did not seem connected to A, B, or C. We proceeded in this fashion with topics E, F, G, and so forth. Eventually I became forgetful, confused, lost, and discouraged.

One such hour, I listened carefully and retained the first 30 minutes of the session. I then said: Let me summarize the session. I did do so in detail, and then asked if he had any ideas about this hour. Somewhat to my surprise, he said he did. He said that what was happening was that he was flitting from topic to topic, and that we never talked together about the same thing for even one minute. Had I noticed? Yeh, I said.

He continued spontaneously, adding that his purpose in flitting from topic to topic was to prevent any closeness: I am treating you just the way my mother treated me. He then described in vivid detail his mother's intolerance of any intimacy with him, her inability to listen to him, and her inability to remember what he said. He began the next hour by describing childhood conversations with her in detail. Her quick changes of subject confused him. His head would spin. He felt as though a real conversation with her was impossible. He couldn't feel close with her. He felt alone and discouraged after each interaction. She repeatedly rejected him.

He related this new material in a more serious and dignified

manner than he had shown previously. This was our longest period of collaboration—of mutuality, of intimacy—to that point.

In this vignette, I acquired the capacity, over time, to tolerate, and to begin to master, the trauma inflicted on me—the trauma which he experienced as having been inflicted on him in childhood by his mother. As I did so, I not only became aware of my feelings, but I could observe our interaction more closely, and could remember and relate what was happening between us. This capacity enabled Mr. A., through transient identification with my capacity, to acquire the strength to begin to face the details of his mother's rejection of him, and of the feelings it had aroused in him.

My formulation is based on the psychoanalytic theory developed by Joseph Weiss (1986). According to Weiss's theory, Mr. A., in carrying out this enactment with me, was unconsciously testing a pathogenic belief he had acquired in childhood in relation to his mother. He believed unconsciously that he was rejected by his mother because he was stupid, inadequate, and a bad person; and he believed that he deserved to be treated in this way. Because he believed that her contempt and rejection were deserved, it was too painful for him to face what had been done to him, to remember it clearly and in detail, to think about it, and to master it. In inflicting this trauma on me, he unconsciously hoped that I would not be as traumatized as he had been. He hoped I would be able to face it, to think about it, and that I would not believe that it was my fault—that is, that I would not believe that he treated me this way because of my inadequacies and my badness. My ability to face my own feelings, to think clearly and explicitly about what was happening between us, and to talk about it, meant to him that I did not feel responsible for his contempt and rejection. This helped him to disconfirm his pathogenic belief, and to recall the childhood circumstances in which it arose, and his own childhood feelings.

In all three vignettes I have presented, a patient became aware of certain of his or her transferences, and began to make some progress toward analysis of these transferences. These changes took place spontaneously—that is, without direct interpretation by the analyst. Such observations may be made regularly in psychoanalysis. We have done so both clinically and in our research, and have found lawful sequences between the disconfirmation of a

pathogenic belief and immediate analytic progress. I should like to make a few points about the implications of such observations for our understanding of the analytic process:

1. These observations demonstrate the powerful role of the actual experience between patient and analyst in facilitating analytic progress, including in the resolution of previously unconscious transferences. An experience with the analyst may, in some circumstances, disconfirm pathogenic beliefs, and thereby enable the patient to become aware of unconscious aspects of his transferences.

2. These observations also demonstrate the crucial importance of the patient's unconscious appraisals of danger and safety to his analytic progress. For example, as Mr. A. began to disconfirm his painful unconscious belief that his mother rejected him because he was stupid, inadequate, and bad, he felt safe enough to remember her rejections and how he had experienced them as a child. He also felt safer—because he was less in the grip of the belief that he was stupid, inadequate, or bad—to begin to risk openly collaborating with me. For example, if I were to reject him after he had disconfirmed this belief, he could recognize that this was due to some undesirable trait of mine rather than of his.

We have demonstrated in our formal research studies that patients continuously monitor the analyst's behavior and attitudes unconsciously. They show indications of immediate progress when interpretations, or other activities by the analyst, disconfirm pathogenic beliefs and thereby reduce their unconscious sense of danger.

3. These observations show that patients may acquire insight into previously unconscious transferences, and recall previously unconscious memories and gain access to previously inaccessible feelings, on their own—i.e. without interpretive help. This suggests that patients are unconsciously motivated to resolve unconscious conflicts, and may be able to work unconsciously to do so. For example, they may test unconscious pathogenic beliefs in relation to the analyst.

Such testing is not simply an automatic repetition of the past, or an unconscious resistance, or an unconscious effort to perpetuate the past in the present. It is an attempt to learn something about the analyst that may help them to disconfirm an unconscious transference expectation that is interfering with their progress.

A final comment on these vignettes. The first example, Ms. Y., illustrates what we refer to as a transference test. The patient, in being late, carried out a trial action that exposed her to the trauma she had experienced in childhood in relation to a parent. The two other vignettes illustrate what we refer to as passive-into-active testing. The patients carried out a trial action of inflicting a trauma upon the analyst such as the parent had inflicted on the child. In thus reversing the childhood roles, the patient does actively to the analyst what he had experienced passively in childhood. In such instances, the analyst experiences the trauma to some degree, works it over in his or her own mind, and gains some mastery of it, and this helps the patient to begin to do so. Passive-into-active testing is of particular interest not only because it is common in treatment, but because the patient's behavior during it seems resistant and anti-analytic, as in Mr. A.'s devaluing of me and our work, confusing me, and rejecting me. But such behavior may be a part of a patient's unconscious work to overcome pathogenic beliefs and to solve his problems.

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