

Sources of Obstacles in the Course of Therapy¹

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In this short communication attention is drawn to some particular sources of disturbing factors in the course of psychotherapy. These factors do not stem from lack of training, knowledge, or experience. They can happen to the best trained and experienced therapist, because they arise from the interference of unsolved residues of his own problems which are bound to subsist however successful his own analysis may have been. Since this occurs against his better knowledge and best will, it endangers the results of his work; this can occur at any stage of the therapy, from the first interview to the end. The stimulants which arouse such difficulties and even disturbances may be any elements, peripheral or central. However, we can point out two clearly distinct fields in which they may be located; on the one hand, the therapist's attitude to the therapeutical situation as such; on the other hand, his attitude towards the patient.

As far as the attitude to the therapeutical situation is concerned, this kind of obstacle depends largely on the degree to which the therapist has relinquished his set role within his nuclear family situation and whether he is able to be cast in any other role but the one he cherished or aspired to in childhood. In supervising trainees in psychotherapy one sees clearly how much the family situation influences the content of the therapeutical situation. For instance, if an over-ambitious trainee complains that he has no quick or tangible results, besides helping him technically, I keep in mind Adler's advice to search for the "brilliant cousin." Of course this is a much over-simplified example, given merely to indicate how the past mingles with the present. But the supervisor's own approach to the task of supervising is influenced too, by similar factors. One can distinguish two very different basic attitudes toward supervision: some supervisors identify themselves with the case as if it were their own and not that of the trainee, who then plays a secondary role. Others are much less concerned with the case as such and most of their attention is given to the personality of the trainee. Many an experienced therapist will

¹ Synopsis of paper presented to the International Congress of Individual Psychology, Zürich, July 26-29, 1954.

make discoveries about himself, and often very surprising ones, if attention is given to this point.

Turning now to the therapist's attitude to the patient and to factors which might impair the therapeutical success, we come to the problem of "transference" and "countertransference," which was the sole topic of the preceding Congress here in Zürich.² What I heard then in the field of terminology was more confusing than enlightening to me.

We Adlerians have had many discussions as to whether the term "transference" could or should be used by Adlerians since it was coined and generally is used in the Freudian libidinous concept. I myself suggested the term "projection" instead of the term "transference," but others objected that this meant something quite different. At the Congress many excellent therapists conveyed the opinion that both terms could be used and were interchangeable. Then came others equally well reputed who said the two terms represented two quite different phenomena. So again I had to choose my own terminology. I chose, and shall use here, the term "transference" until we find a better one, which I hope we will do, soon. But it is very important to me to make clear that I do not accept the libidinous connotation implied by the original Freudian concept. I am not willing to accept it, either theoretically or in practice, because my experience has taught me differently.

Thus I do not hesitate to use the term "transference" in an Adlerian paper because we Adlerians are not in danger of forgetting our convictions just because we make use, in our own way, of terms coming from elsewhere. Those who are afraid to do so remind me of alcoholics who dare not take a single drop of liquor. We can afford to take "a drop of liquor" without danger, as long as we have no "alcoholic" tendencies. Yet I like to stress the point that I am speaking only for myself, not involving any of my colleagues, many of whom believe differently.

My experience has taught me to acknowledge the oft repeated phenomenon that even the best rapport between therapist and patient can be shaken when manifestations of transference or countertransference occur. I learned to accept this as nearly inevitable, because according to my conception, transference is the process by which any unsatisfied emotional need is projected on and attached to the thera-

² International Congress for Psychotherapy, 1954.

pist's personality. And a similar process, but in reverse, constitutes the countertransference. Since all our emotional needs can never be satisfied, this kind of transference is bound to occur.

Why, when, and in which way manifestations of transference and countertransference occur is highly symptomatic and indicative of the style of life of the person involved. I consider it as valuable a signpost as early recollections and dreams. To give examples within my experience would mean giving case histories, which cannot be done here, but can be found in a former communication, "Pitfalls in Psychotherapy."³ However, if any experienced therapist insists that he never encounters and therefore "does not believe" in any kind of transference, in my opinion he might as well say that he does not believe in electricity. Such disbelief does not prevent transference phenomena as well as electricity from existing.

In practicing psychotherapy there is a very important difference between those who admit that transference and countertransference occur and those who deny it. The latter are more prone to be the victims of such an occurrence than to be able to deal with it, because they will not even be aware of it when it occurs; therefore the situation is out of their control. On the other hand, when the therapist is alert to such possibility, he will take it into consideration, watch for symptoms and be able to deal constructively with the situation. Consultations with colleagues certainly are advisable when impediments stemming from such sources are suspected and this usually helps to remove the obstacle. And by that I do not mean discussion of the impeded case but frank discussion of the therapist's own involvement in the case. Sometimes even a short renewal of the therapist's own analysis may be necessary. I, myself, according to the experiences of thirty years, would like to volunteer the suggestion that any therapist who has worked for a long stretch of time should have a short periodical renewal of his analysis. I believe that by these means we could prevent errors and failures stemming from transference and countertransference. And I also believe that this is the true sense of Adlerian teaching. Adler himself often warned us that we should never believe we were perfect, and called it our duty to go from "gross errors to lesser ones."

³ *American Journal of Individual Psychology*, Vol. X, No. 1 and 2, 1952.