

A second look at

Ralph Greenson's Loving, Hating and
Indifference towards the Patient (1974)

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A way (probably now deemed too old-fashioned) of working with
countertransference:
A second look at Ralph GREENSON'S Loving, Hating and Indifference
towards the Patient (1974).

Reflective Introduction

Readers might spot the allusion to Erikson's modest but rigorous depiction of psychoanalysis as a way of looking at things. Old fashioned recognises that revisionist/post-modern psychoanalysts seldom refer to the work of Greenson. The concept of countertransference has undergone extensive revision in the years before and since this 1974 paper. Consequently, Loving, Hating and Indifference ... may strike many contemporary psychoanalysts and dynamic psychotherapists as simple, even simplistic because not allowing for much more interpsychic complexity than Greenson may have recognised as a Freudian. Worse, from this perspective, Greenson does not mention projective identification!

Nevertheless, I like the plain sense of Greenson's paper which (to my mind) serves to remind us that we do experience forms and variations of the triad Loving, Hating, and Indifference during the course of our therapeutic endeavours. In contrast, patients experience a multitude of transferential feeling states towards ourselves-as-therapists. This quantitative imbalance of respective feelings and actions inherent in the (dynamic) therapeutic dyad attests to the interhuman, yet asymmetric, relationship between therapist and patient – a clinical fact discounted by extreme interpersonalists and intersubjectivists. However, we are reminded that it is the patient who is invited to say/voice whatever comes to mind without fear of censure, or undue encouragement, or other intrusions by the therapist who instead listens attentively in the otherwise close collaborative quest for meaning. The last publication by Charles Brenner – frequently criticised, even attacked, by post-modernists and Object Relations Theorists alike for being too dogmatic (sic) – was titled: Psychoanalysis or Mind and Meaning, a simple yet profound farewell message and reminder to the analytic community, and associated dynamic therapists/therapeutic counsellors of whom I count myself as one.

Whereas the analytic patient free-associates 'publicly', the therapist as a rule free-associates inwardly/silently, mostly bounded/tempered by introspection and respect for the responsible work of therapy. Furthermore, the patient for example, can move regularly between over-idealising and denigrating the therapist who may not trade such transferential projections. After all, the patient did not embark on personally demanding therapy so as to be therapist to the therapist. (I am aware that various humanistic therapists regard the therapeutic dyad as two people engaged in co-therapy.) While there is and must be a meeting of (separate) minds if therapy is to be meaningful, the meeting of minds is principally concerned with the welfare of one particular mind: the person-as-temporary-patient who had embarked on the work of self-enquiry having a mind of their own. In truly effective therapy the therapist cannot but learn from the patient: it is one of those SINE QUA NON ingredients of genuine psychological work.

I very much appreciate the Greenson paper and wish to share this appreciation with fellow toilers/tillers in the therapeutic field. Moreover, the paper shows a master clinician at work. There is a particular reason for my use of the word clinician. As a rule, psychotherapeutic writers do not publicise their professional credentials in their texts. Greenson, in his paper writes, not just as a psychoanalyst, but also as a medical doctor/psychiatrist. Indeed, in one of his vivid case examples he describes the eruption of his countertransference identification

with the patient as follows: 'I was swept out of my analytic role by my intense protective feelings for the poor mother and child and also by my hatred for the neglectful doctors, both rooted in my own past. This led me to identify with the patient in her predicament'.

My highlighting Greenson the physician does not mean that medical and lay analysts are better or more preferable than each other. The psychoanalyst and non-practising medical doctor JD Sutherland declared therapy to be 'an act of human concern' (echoes of Erikson, the lay analyst, at the start of this paper). Sutherland had trained originally in science and in psychology and later studied medicine simply to ensure his entry into psychoanalytic training as was then the dominant trend.

The paper: Loving, Hating, and Indifference towards the Patient

I will let the master clinician speak for himself through selected passages lifted from his paper. The focus of my approach to this very modest project is on Greenson's understanding of and approach to the subject matter, their being interweaved in his technique of practice. To appreciate properly and benefit from Greenson the analytic teacher, readers would have to return to the text in its fullness or, in some instances, engage with it for the first time. In either case, they would judge for themselves the paper's relevance and usefulness or otherwise.

... During the course of psychoanalytic treatment, every psychoanalyst experiences many shades and degrees of love, hate and indifference towards each of his patients. This range of feeling is necessary for doing psychoanalytic therapy.

... I propose to use the term countertransference to refer to all the analyst's transference reactions to his patient. Countertransference, like all transference phenomena, is characteristically a distorted and inappropriate response derived from the unresolved unconscious conflicts in the analyst's past. As such it may not be suitable for analytic work unless it can be detected, controlled and modified. There are instances ... when a countertransference reaction is therapeutically useful.

Some analysts affirm that all the analyst's emotional reactions to the patient are countertransference. This 'totalistic' point of view negates the value of discriminating between countertransference reactions and those which are relatively free of countertransference. If there were no real relationship between analyst and patient, no sustained collaborative work would be done and analytic therapy would be ineffective. (Emphasis added. This sentence of course marks Greenson out as an ego psychologist to whom external reality and relatively conflict-free actions are as relevant as inner reality and conflict.) ... I suggest that the 'counter' in countertransference be understood as the duplicate of transference, like the 'counter' in counterpart.

... Many reactions of analysts are mixtures of countertransference and real reactions just as many reactions of patients to their analysts. All countertransference distorts some small, real element in the patient, and all real relationships have some degree of transference. This occurs outside of analysis as well. All relationships consist of different admixtures, blendings and transitions between transference and non-transference components ... Nevertheless, it is helpful to draw clean-cut distinctions between them ...'

Following an illuminating clinical example, Greenson noted: ... 'In my style of working, not answering the patient's question would have been wrong and due either to my fear of countertransference or to indifference'.

... Thus far I have only described countertransference reactions, the sporadic, transitory responses ... Analysts also develop countertransference neuroses, long-lasting transference involvements with their patients, in which the patient becomes persistently and inappropriately of central importance to the analyst. Such reactions can be intense as, for example, the analyst who falls in love with his patient or desires sexual relationships. If hatred prevails, the analyst may have frequent temper outbursts, or he may approach every hour with the patient with a sense of dread ... a type of internal groaning, or an attitude of pugnacity, as if he were meeting an opponent, an adversary, not a patient. This latter attitude is very frequent and leads analysts unknowingly to engage in constant one-upmanship in their interventions. In such cases the analysis is a contest and the patient is never allowed to end up being in the right.

The more subtle forms of countertransference neuroses are more dangerous because they are more difficult to detect. Persistent and undue protectiveness, rescue fantasies, chronic and unyielding goodnaturedness and benevolence are indicators of a motherly countertransference neurosis and are more frequent in female analysts. Constant boredom, forgetfulness, coldness, aloofness or indifference are often indicators of a warded-off hostile countertransference neurosis.

... It is not only the analyst's instinctual needs and the defences against them which may lead him into countertransference reactions, but also his narcissistic needs. For example, pathological therapeutic ambition may lead him to idealise his patients, exaggerate their capacities, and become repeatedly disappointed in their slow progress.

... Just as the psychoanalytic situation is tilted, facilitating the patient's development of transference reactions and a transference neurosis, it is also tilted for the analyst, but by other elements contained in it. The analyst encourages full expression and is then exposed to the patient's loving and hateful feelings. The analyst usually delays his responses so he can think, introspect, empathise, understand and eventually formulate his intervention in a relatively low key. These activities are a strain because of the instinctual stimulations and frustrations. In addition, he has to bear the narcissistic blows or gratifications from the patient's material and behaviour. Furthermore, extraordinary experiences in the analyst's life may make him temporarily excessively susceptible to countertransference reactions as for example, personal miseries, illness or a death in his family, a pregnancy, the loss or suicide of a patient, etc. If the patient's material coincides with these extraordinary events in the analyst's life, the analyst is more likely to react with countertransference. Self-observation and control may make these reactions very useful, however.

... Reactions appropriate to the working alliance in the analyst are analogous to those in the patient; his real relationship to the patient, his concern for his welfare and his devotion to the analytic situation.' (Presumably, every thoughtful dynamic therapist practices to this degree of skilled considerateness. A contemporary of Greenson's, Edward WEINSHEL, shared this attitude and approach and who, on his death, was described as the conscience of official American psychoanalysis. Interestingly Sutherland in one of his writings spoke of the devoted therapist. Without naming it as such, Greenson, Weinschel, Sutherland (and Erikson) were exercised by the ethical dimension of psychoanalysis. We could say they all implied a strong social conscience in their thinking and actions, more explicitly so in the case of Erikson: he was in the front-line of the US Civil Rights marches. Sutherland spoke of autonomy within heteronomy, reminding us we are fatefully human-social-beings. Furthermore, he stressed the need for responsible care and responsible autonomy: ethico-

moral commands/calls of personal conduct for therapists and patient alike as members of a wider civil society/moral universe or life-world.)

... An indispensable vehicle for understanding the patient's unconscious is the analyst's capacity for empathy. Empathic contact with the patient is more reliable when it is motivated by the working alliance. This is the optimal condition. Countertransference may be stirred up by empathic contact with the patient but leads to inappropriate conduct, not always in the service of the working alliance ...

Sometimes countertransference reactions, if not recognised, can lead to a loss of empathy and will result in errors in the dosage, timing or tact of interpretations or to acting out by the analyst.

... The consciousness of countertransference feelings may be the analyst's first indications of goings on in the patient of which he, the analyst, had been oblivious ... This point was first stressed by HEIMANN (1950) and LITTLE (1951). This occurs particularly frequently in the analyst's responses to the primitive impulses and fantasies so often found in the borderline and psychotic patient. The use of our usual neutral position at such times may become an unconscious defence against our more spontaneous responses to these primitive stimuli, both loving and hateful, a defence which sometimes but not always, coincides with what is therapeutically indicated.

... The first step in establishing control is to recognise that we are experiencing a countertransference reaction. This means that the analyst, as he listens, must be aware of his thoughts, feelings and impulses as well as their absence. Then he must confront himself with the question: is what I am thinking or feeling in keeping with the patient's material or behaviour, and is my intended intervention potentially helpful for the patient or being undertaken for my own needs? This sounds like a lengthy process but in reality it happens in a flash ...

... All intense emotional reactions are suspect whether they are loving or hateful. Amorous feelings, sexual desires, sadistic impulses, disgust, fear, sadness and idealisation are some of the most frequent transference reactions in the analyst. (Emphasis added.)

... The absence of feelings, indifference, is a sign of countertransference. You cannot work well with a patient unless you like him and are interested in him. The liking should not be intense: that would indicate a strong countertransference. On the other hand, one cannot work effectively unless one is willing and able to become emotionally involved. It is not possible to empathise with a patient unless one feels a goodly amount of liking. If the quantities are moderate, the analyst can then attempt to take a neutral position in attending to the patient, ie he can become an interested observer of the patient's conflicts without being impelled to take the side of one contending aspect. Neutrality stems from the loving aspect, the concerned attitude of the analyst. (Emphasis added. So much for the frequent accusations by, among others, extreme subjectivists and humanistic therapists, that the neutral therapist is emotionally distant/unavailable and a mere technician.)

... Indifference indicates either an emotional frigidity in the analyst or a defence against his feelings or impulses. The only time indifference may be a therapeutic response is in regard to intense and prolonged emotional outbursts in borderline and psychotic patients. They may need your indifference to reassure themselves that their hostile or sexual assaults are not deadly or overwhelming you. They may need you to act as though inanimate. (SEARLES,

1963). Also, you may need the withdrawal into temporary indifference to sustain your capacity for working with such patients through time. (Emphasis added.)

... It is well known that analysts may act out their unconscious emotional needs with their patients by becoming seductive or punitive or combinations of the two. It is less well known, but quite frequent, that analysts will act out their indifference, especially if it is a defence, by over-interpreting, as though the patient possessed a built-in mechanical comprehending apparatus. In this way the patient is never able to build up any emotional intensity towards the analyst. Over-interpretation then serves as a counter-phobic activity, or reaction formation ...'

Finally, towards the close of his paper Greenson observes: 'Let us assume you have detected the pressure of countertransference in yourself. What do you do next? Sometimes detection is all you can do in a given instance and that insight is sufficient to restrain you from intervening or it may enable you to modify your response.

... It is, I believe, correct psychoanalytic technique to admit one's behavioural lapses to the patient ... namely one should admit a behavioural lapse before attempting any interpretations, because analysing before such an acknowledgement may be correctly perceived by the patient as an attempt to minimise the analyst's error.'

This principle of correct/ethical practice ends my selection of quotes from Greenson's paper. Since the dynamic, ie emotionally involved therapies are such private encounters, even hermetic in some cases, one can only hope that the majority of practitioners will strive to conduct themselves consistently, scrupulously and considerately (cause no hurt) and, whenever we detect our behavioural lapses we own rather than disown them, thereby learning from our errors as well as from our patients who are temporarily but fatefully dependent upon ourselves for a special kind of responsible care.

Concluding remarks

I suggest that Greenson's paper is more than of historical interest. It makes me think of a much earlier work by a physicist turned brilliant psychoanalyst, Robert Waelder: The Principle of Multiple Function, in the form of a question: might it be that the contemporary therapist's various countertransference reactions fatefully include vicissitudes – 'particles' however minute – of Loving, Hating and Indifference towards the Patient? If so, then there is much more to Greenson's triad than meets the eye (and ear for that matter).

This paper about a paper is dedicated to another master clinician, Dr John Evans, who, forty years ago, encouraged me and others how to think psychoanalytically and in the process always impressed us with his plain sense of things therapeutic.

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Also

MEISSNER, W.W. (2003). The Ethical Dimension of Psychoanalysis. State University of New York Press. Meissner is the so-called arch-conservative Freudian. However he is a formidable Freudian Scholar! This might explain the tendency to caricature him by certain sections of the analytic community.

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