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THE PSYCHOTHERAPIST'S IDENTIFICATION WITH THE PATIENT

BY

PAUL GELTNER

A dissertation submitted to the Graduate Faculty in Social Welfare in partial fulfillment of the requirements for the degree of Doctor of Social Welfare, The City University of New York.

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ABSTRACT

The study was designed to explore the phenomenon of the psychotherapist's experience of identification with the patient. Twenty experienced psychoanalytically oriented psychotherapists were interviewed. The interviews were conducted from a qualitative phenomenological orientation, with the use of an interview guide. The data collected in the interviews was subjected to an inductive analysis. The findings included: a typology of identifications experienced by therapist; an analysis of the positive and negative effects of identifications on the treatment process; an analysis of the factors which helped therapists to recognize identifications; and an analysis of factors which tended to make therapists lose control or help therapists to maintain control of the experience of identifying with the patient.

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HISTORY

Preliminary Statement of the problem

This study was designed to explore and describe the phenomenon of the psychotherapist's identification with the patient. This phenomenon includes the therapist's experience of thinking, feeling, behaving, or relating to others in a way that is clearly similar to the way that the patient thinks, feels, behaves, or relates to others. Various manifestations of the phenomenon have been reported in the literature, ranging from mild experiences of conscious empathic understanding of patient feelings to unconscious re-enactments of patient behavior, both within and outside of the therapeutic setting. However, most of the literature on this subject has been theoretical and didactic in nature. There has been little systematic exploration of how the phenomenon is actually manifested in clinical practice.

This study explored the phenomenon as it is manifested in the therapy, the supervisory process, and the therapist's personal life. It utilized a phenomenological qualitative research methodology to interview psychotherapists about their experience of this phenomenon. The interviews explored the full range of this phenomenon, including both the ways in which it was experienced as a normal, expectable and essential aspect of psychodynamic psychotherapy, and the ways in which was a disruptive factor in any aspect of the therapeutic process.

Personal motivation for the study

One of the most interesting and challenging experiences that I have had in the course of my own experience as a clinical social worker engaged in the practice of psychotherapy has been the experience of identification with my patients. When I first began practicing as a student, the concept of empathy -- of understanding patient feelings in an emotional, as opposed to intellectual manner -- seemed relatively straightforward. It was often easy to integrate this concept in my clinical work. Patients described their sadness, or their anger, or their frustration, and it seemed natural to experience a taste of their feelings myself. When things were going smoothly, it was obvious that it was *their* feelings that I was experiencing vicariously, and it was also obvious that I did not feel them as intensely as they themselves did. It also seemed clear that the success of the treatment depended, at least in part, on their feeling that I understood them, and the experience of empathy made that understanding possible.

At times, there was an uncanny quality to the experience, as I found that in session I sometimes involuntarily imitated my patients' inflections, vocabulary, and ways of thinking. And outside the sessions, it was strange to find myself enjoying the same type of music that they did, or even looking at political issues from their perspectives rather than from my own.

Occasionally, however, the whole experience felt much more dangerous. With depressed patients I often found that I was so identified with their despairing vision that no solutions to their problems could be found that I became as depressed as they were. Or, as they would carry on about the inadequacies in their characters, I would find myself brooding about the inadequacies in *my* character. It was as if I had caught their disease.

Occasionally, I was able to recognize the similarities between the patient's state and my own state by myself. At other times it was only through discussing the case in supervision that I was able to see that my feelings were a reflection of the patient's feelings. Although I had done extensive reading on theories of countertransference, nothing really prepared me for either the subtle and elusive quality of the experience, or for its pervasiveness. Although some types of countertransference seemed easy enough to spot, the experience of identifying with the patient was often the most difficult aspect of my emotional response to get an objective perspective upon. Yet when I was able to do so, my ability to manage the case almost always improved, and my overall level of comfort with the patient increased dramatically.

As a clinical supervisor, I have found that focusing on the therapist's identification with the patient has almost always increased the therapist's understanding of the therapeutic process. And in the course of teaching master's

level social work students, I have consistently found that introducing the concept of the identification with the patient opens up a new dimension in their understanding of their clinical work. Students report that experiences with patients that were frightening and confusing become manageable, if not clear. While the problems associated with the identification with the patient do not disappear, their existence is now recognizable and identifiable. What often seemed like a personal problem became transformed into an expectable part of the process.

Thus far, my understanding of the phenomenon has been shaped by my own reading and by my personal experience. Of course, I have also learned a lot from my students and from my supervisees, but what I learned from them is also heavily shaped by what they have learned from me. What I was lacking was a better idea of how other therapists experienced the phenomenon of the identification with the patient. What was this experience like for them? How intense did it get? What role did it play in their work? And how did they manage it if and when it became too intense?

These were the questions that led me to develop this study.

History, saliency and dimensions of the problem

The phenomenon of the therapist's identification with the patient was first identified and most fully explored within the context of psychoanalytic theory. However, the phenomenon has a direct bearing on social work theory and practice. The history of the problem within psychoanalytic theory will be discussed first, followed by a discussion of the implications for social work theory and practice.

History of the problem within psychoanalytic theory

Beginning with Freud (1912), numerous psychoanalytic theorists have attempted to describe the experience of the psychotherapist feeling the patient's feelings as though they were her own. The nature of this experience has been conceptualized in a variety of ways. Freud (1912) suggested that the therapist's unconscious can understand the patient's unconscious. Fliess (1942) argued that the therapist forms a transient identification (or counteridentification) with the patient. Kohut (1959), Greenson (1960), and Arlow (1963) have described the experience as empathy. Winnicott (1949), Heimann (1950), and Racker (1957), others have viewed it as a form of countertransference.

The concepts of unconscious understanding, identification, empathy, and countertransference all refer to a broader spectrum of phenomena than the therapist's experience of feeling the patient's feelings. Nevertheless, each touches on the more limited phenomenon of the therapist's

experience of feeling the patient's feelings, and each illuminates it from a slightly different angle. For the purpose of this study, this phenomenon will be called *the therapist's identification with the patient.*

All theorists agree that some degree of identification with the patient is necessary if the therapist is to fully understand the patient. Fliess (1942) argued that a "conscientious" therapist will not be able to avoid the experience of feeling the patient's feelings as if they were her own. Heimann (1950) said that countertransference alerts the therapist to the "most urgent elements" in the patient's communication. Kohut (1959) argued that the use of empathy was the factor that distinguished observation and investigation of psychology from the investigation of the physical world. And most psychoanalytic psychotherapists would agree with Greenson's (1960) comment that a therapist who is unable to empathize with his patients is unable to fully understand the patient's feelings, affects, and subtle, non-verbal communications. Kohut (1984) goes so far as to view the failure of empathy to be the major cause of unsuccessful treatments.

Thus, the therapist's identification with the patient is a crucial part of the psychotherapeutic process.

At the same time, however, the literature on the therapist's identification suggests that the identification can pose serious threats to the success of the treatment if

the therapist loses control of the experience. (Fliess, 1942; Greenson, 1960; Beres and Arlow, 1974). The therapist who loses control of his empathy lacks the degree of detachment from the patient that is required in order to intervene properly.

It has also been suggested that this experience can be threatening to the therapist's own mental health. Fliess (1942) described the process as a "danger-situation" for the therapist. Spotnitz (1985) has suggested that severe countertransference reactions to schizophrenic and other severely disturbed patients can lead to the development of psychotic or psychosomatic illness.

The therapist's identification with the patient can have a significant impact on the supervisory process as well. This can be see in one of the most vivid examples of identification --- the parallel process -- the peculiar situation in which a therapist involuntarily and unconsciously re-enacts the patient's behavior in the supervisory relationship. Here, the identification appears to have taken over the identifier -- at least temporarily -- and the therapist has lost conscious control of the experience. Both therapist and supervisor can become utterly confused if they do not recognize what is occurring (Searles, 1955; Mattinson, 1975).

Finally, the therapist's identification with the patient can have an impact on the functioning of the agency as well as on the individual psychotherapist. Searles (1975), for

example, has described how identification processes with paranoid patients can become manifested in problematic ways in the therapist's relationship with the treatment team in a hospital setting. Sigman (1989) has described how the phenomenon can be a disruptive force in case conferences.

Thus, the identification with the patient is a potentially dangerous phenomenon. While it is deemed both inevitable and necessary to the therapeutic process, it is an experience that is fraught with peril for the therapy, the therapist, the supervision, and the agency.

History of the problem in social work and relevance to current social work practice

The phenomenon is of significant relevance to the practice of clinical social work in a number of ways. First, the majority of the psychotherapy services in the country are provided by social workers, and a significant number of social workers practice psychotherapy. Thus, the phenomenon is relevant to a significant number of social work practitioners and social work clients.

The phenomenon has been observed frequently in hospital and agency based practice (Searles, 1955; Mattison, 1975; Sachs and Shapiro, 1976; Nadler, 1976; Kahn, 1979; Davenport, 1984). Furthermore, Mattinson's (1975) discussion of the phenomenon in casework with clients seen in the criminal probation system demonstrates that it is an important factor

in work with clients who are being treated outside of traditional mental health settings.

Secondly, the therapist's identification with the patient is directly relevant to the type of patients that social workers are likely to treat. Some studies have noted that more disturbed patient populations, including borderline and psychotic patients, are likely to arouse powerful countertransference reactions which may include intense therapist identifications with the patient (Searles, 1975; Spotnitz, 1984). These types of patients are routinely treated by social workers in agency and hospital settings.

Similarly, the importance of the phenomenon in the treatment of patients suffering from Post Traumatic Stress Disorder (Wilson and Lindy, 1994) -- a patient population that is currently receiving considerable attention in the literature -- has recently been emphasized. McCann and Colletti (1994) describe the phenomenon of vicarious traumatization, in which therapists treating patients who have been physically or sexually traumatized begin to feel that they are feeling the same types of trauma. This experience creates a considerable degree of stress in the therapist, and can lead to the therapist becoming completely overwhelmed by the patient. Danieli (1994) argues that training in countertransference should be given first priority for therapists who work with trauma patients. This patient population includes survivors of physical and sexual abuse,

children exposed to violence either in their homes or in their communities, war veterans, and some groups of immigrants. Again, these types of patients are routinely treated by social workers in settings which include hospital emergency rooms, child guidance centers, women's shelters, and foster care agencies.

In spite of the relevance of the phenomenon to the services that social workers provide and the client populations that they treat, it has received inconsistent attention within the social work literature. Studies of how the phenomenon is manifested and actually utilized in the supervisory process -- the parallel process -- in social work literature are few in number but well developed. Mattinson (1975) gives detailed examples of how the worker's identification forms a crucial part of the supervisory process in family cases in social work settings. Similarly, Kahn (1979) describes a number of cases, involving both social workers and social work students, in which understanding the worker's identification with the patient was crucial to resolving the worker's impasse with the case. And Davenport (1984) views the identification as being at the heart of the training process, and describes how it is utilized in the supervision of case in a post-graduate training clinic. These studies are extremely sophisticated contributions to the literature. Mattinson's (1975) monograph on the role of identification in casework supervision, for example, is the

most detailed descriptive and theoretical account of parallel process (Mattinson uses the term 'reflection process') to found in any of the mental health/social work literature.

However, discussions of the phenomenon as it is manifested in settings other than supervision -- the therapeutic process itself, and the therapist's outside life -- are lacking. References to the broad phenomenon of the therapist's identification with the patient-- usually in the context of warnings about the problem of over-identification with the patient -- can be found in the general literature on clinical social work. For example, Strean (1978) writes that,

> frequently a client stirs up in the social worker feelings of identification with him, and the worker may reject those parts of the client that he dislikes in himself, and champion those aspects that he likes in himself (p. 208-209).

There are also references to the phenomenon in the social work literature as regards how the phenomenon can become a danger with specific populations. Dunkel and Hatfield (1986) describe the problem of overidentification with AIDS patients, and Schernoff and Springer (1992) describe it with AIDS patients who are substance abusers.

Dimensions and scope of the problem

If it is true that the therapist must form some degree of identification with the patient in order for the therapy to work (Fliess, 1946; Kohut, 1956, 1984; Greenson, 1960; Arlow, 1963), then the phenomenon would appear to be a significant factor in all social work psychotherapy.

The therapist's identification with the patient has been studied most extensively within the framework of psychoanalytic theory. And it is within the context of psychoanalytic psychotherapy that the identification is most likely to be identified and utilized.

However, the concept of the therapist's identification with the patient differs from many other psychoanalytic concepts, (such as transference) in that it is phenomenologically identifiable without the support of other aspects of psychoanalytic theory. As such, the occurrence of the phenomenon is not dependent upon the therapist being psychoanalytically oriented in her clinical thinking. Nor is the phenomenon intrinsically related to the use of psychoanalytic interventions or technique.

The identification with the patient should viewed not as a deliberately selected technique but as an involuntary experience (Searles, 1956; Greenson, 1960; Arlow, 1963) that is aroused in the therapist as a consequence of the interaction with the patient. The experienced can be

acknowledged or ignored, studied or suppressed, but it cannot be eliminated.

As such, its occurrence is not limited to psychoanalytic psychotherapy, and it has been observed in other types of psychotherapy as well. For example, Marohn (1969) and Fulop and Schuman (1987), working with a group systems orientation, report examples of psychotherapists re-enacting patient behaviors, which they refer to as *process parallels*. These re-enactments appear to be phenomenologically identical to the types of identifications with the patient that are described in the psychoanalytic literature as parallel process. Fulop and Schuman (1987) note that this type re-enactment of patient behaviors has been observed frequently.

It has been suggested that the issue of grappling with countertransference (a broader phenomenon which includes the therapist's identification with the patient) is important no matter whether the therapist's orientation is behavioral or psychodynamic (van der Kolk, 1994). There is no reason to believe that this is not true of other orientations as well.

The therapist's identification with the patient has been described in psychotherapeutic work with patients from a wide range of ethnic and cultural groups. It has been described in work with victims of state terrorism in Chile (Agger and Jensen, 1994), Dutch WW II resistance fighters, rape victims (Hartman and Jackson, 1994), Viet Nam veterans (Maxwell and Sturm, 1994) and inner city African-American children (Nadler,

1994). Comas-Diaz and Jacobsen (1991) describe it as a problem that can arise when the therapist and the patient are of the same ethnic group. This also suggests that the phenomenon is a universal occurrence within the field of psychotherapy that is not limited to either a particular setting or to a particular patient population.

Past attempts to deal with the phenomenon and prior research on the topic

Previous research on the phenomenon of the therapist's identification with the patient is drawn primarily from literature on the topics of identification, empathy, and countertransference. While there has been a significant amount of theoretical work on the subject, the phenomenon itself remains elusive, and knowledge about it remains fragmented and incomplete.

The phenomenon can be manifested in three different areas within the psychotherapeutic process:

1) The psychotherapy itself

2) The supervisory process

3) The therapist's outside life

A brief critical overview of prior research on each of these areas in relationship to the theory and practice of clinical social work will be discussed in turn.

The psychotherapeutic process

The importance of this aspect of the therapist's identification with the patient is reflected in the literature on empathy and, to a lesser degree, the literature on countertransference. On one hand, the identification is viewed as being essential to the therapist's ability to understand the patient (Freud, 1910; Fliess, 1942; Heimann, 1950; Greenson, 1960; Kohut, 1963). On the other hand, an out-of control, or overly intense state of identification can prevent the therapist from maintaining sufficient distance from the patient to be able to translate the understanding into effective interventions (Arlow, 1963; Greenson, 1960). Giovacchini (1989) describes a number of vivid examples of how identifications with the patient can stalemate the therapeutic process.

The vast majority of the literature on empathy, identification, and countertransference has been theoretical in nature. This literature -- especially the countertransference literature -- abounds in clinical vignettes. For the most part, however, the vignettes are used to illustrate theoretical propositions. Thus, it tends to be didactic rather than exploratory in nature. For example, Greenson (1960) and Beres and Arlow (1974) both offer a number of examples of empathy in clinical practice within the context of theoretical models of empathy. In these, as in most of the studies, the clinical material has been subordinated to

the general theoretical argument, as opposed to serving as data for research purposes.

Thus, the claim that the therapist's identification with the patient is a crucial element in psychotherapy has been coupled with a paucity of information about how the phenomenon actually manifests itself in the treatment setting with a range of therapists, either in in-control or out-of-control ways.

Training and supervision

The parallel process -- the tendency of therapists to re-enact patient behaviors within the context of the supervision --is the manifestation of the therapist's identification with the patient that has been the subject of the most descriptive research and theoretical analysis. Within this literature; it is also the only manifestation of the phenomenon which has been studied in detail in the clinical social work literature.

Numerous clinical examples of the process are described in the literature, accompanied by a welter of generally conflicting explanations of the process. There have also been explanations of the process which link it conceptually to theories of empathy and/or countertransference (Searles, 1955; Arlow, 1963; Mattinson, 1975; Kahn, 1979; Gorkin, 1982).

Much of the literature has focused on clearly visible examples of the phenomenon as it has been observed by supervisors in their supervisees. For the most part, these

examples have been expressed in behavior; this is to say that the therapist is observed to be *acting* like the patient.

The less immediately apparent phenomenon of the therapist thinking or feeling like the patient has been noted (Mattinson. 1975; Kahn, 1979; Davenport, 1984; Arlow, 1985), but has received less emphasis. Some of the literature suggests that these more subtle manifestations of the process have not been sufficiently explored. For example, Doehrman's (1976) work described manifestations of the process so unobtrusive that they escaped notice by either the therapists or the supervisors. And the literature on empathy and on countertransference gives numerous examples of extremely subtle manifestations of the phenomenon, many of which would not be readily apparent even to highly observant supervisors. Jacobs (1991), for example, argues that many unobtrusive types of countertransference enactments can be camouflaged or rationalized as aspects of standard psychoanalytic technique.

While some studies suggest that parallel process is common in beginning psychotherapists (Eckstein and Wallerstein, 1956; Sachs and Shapiro, 1976; Nadler, 1976), others argue that parallel process plays a significant role in the supervision of therapists are all levels of experience, even the most advanced (Searles, 1955; Mattinson, 1975; Gediman and Wolkenfeld, 1980; Caligor, 1981). This suggests that the phenomenon is of relevance to the supervision of

clinical social workers who are at any point in their professional development.

The therapist's outside life

This aspect of the phenomenon has received the least attention in the literature. However, the few ideas that have been proposed suggest that it is an extremely important one. Fliess's (1942) idea that the process of identifying with the patient can lead the therapist into either depression or masochism, and Spotnitz's (1984) suggestion that poorly managed countertransference reactions can lead to psychotic episodes or psychosomatic illness both indicate that this is an area that warrants further exploration. Wilson and Lindy (1994) and McCann and Colletti (1994) particularly emphasize the importance of managing the identification with the patient in work in Post-Traumatic Stress patients. It would also appear that this phenomenon might be an important element in understanding therapist burn-out. More knowledge about this aspect of the therapist's identification with the patient may be crucial to preserving the mental health of the psychotherapist, to minimizing or preventing burn-out, and to managing the impact of the practice of psychotherapy on the personal life of the social work psychotherapist.

Need for the study in light of general conclusions about the literature

The importance of the therapist's identification with the patient has been well established by the literature on

identification, empathy, and countertransference. The theoretical formulations about the phenomena are well developed, and form an important part of psychodynamic theory in general.

However, the prior literature may be said to suffer from the lack of a research focus in general. With the exception of a few systematic studies (Doehrman [1976] is a significant exception), however, most of the literature is explanatory rather than exploratory. Clinical examples are used primarily to illustrate and strengthen theoretical arguments. In the psychoanalytic literature, there is a paucity of phenomenology and almost a surfeit of theory.

Furthermore, much of the literature -- especially the literature on empathy -- has a tendency to be prescriptive rather than descriptive. Those studies which are descriptive are based on a few isolated anecdotes. None of them has explored how the phenomenon is experienced by a larger sample of psychotherapists

There was a need for a more in-depth description of the full range of ways in which this phenomenon is expressed in order for therapists, supervisors, and teacher to better understand how to identify and manage the process of identification as it arises out of the therapeutic process. It is this need that the present study was designed to address.

Related Issues

Thus far, the discussion of the therapist's identification with the patient has been restricted to the context of the practice of psychodynamic psychotherapy. The present study (see sections on Goals and Methodology) will be focused on that setting alone, and will not address related areas unless these issues are manifested in a significant way in the course of the qualitative investigation.

Nevertheless, analogous phenomena have also been described
in non-clinical types of helping and/or supervisory relationships. Raphael and Wilson (1994) describe the emotional reactions of helpers and/or rescuers at the scene of a disaster in terms of countertransference. Similarly, Dunning (1994) conceptualizes the types of emotional reactions that (non-clinical) supervisors and trauma investigators experience in relationship to employees who have been traumatized at the workplace as a form of countertransference. These reactions include the experience of identifying with the traumatized worker.

If countertransference can serve as a useful construct for understanding emotional reactions to trauma in non-clinical settings outside of social work (Dunning, 1994; Raphael and Wilson, 1994), then it might also serve as a useful framework for understanding the emotional reactions of social workers to clients in non-clinical settings. This

would move the significance of the phenomenon beyond the realm of psychotherapy into the broader issues of direct service delivery as a whole.

For example, I have observed a phenomenon which is clearly analogous to the therapist's identification with the patient operating at an intra-agency level, at an outreach clinic serving the homeless population and at an out-patient child psychiatry clinic. It was not uncommon in either clinic for a client to present themselves either to the in-take worker or to the secretarial staff in a state of panic. The secretary or the in-take worker would then panic himself, and communicate this panic to a clinical worker. At times the panic would spread throughout the agency, advancing through the supervisory staff and often engulfing the unit chief as well. No actual treatment had even taken place at this point, but the patient's anxiety would pervade the clinic. It was as if each of the workers at the agency, both the clinicians and the non-clinicians, were identifying with the person who communicated the patient's state of panic to them. The similarity between these phenomena and the therapist's identification with the patient -- especially as described in the parallel process literature -- are clear.

The non-clinical settings described by Dunning (1994), Raphael and Wilson (1994), and the intra-agency example that I have described, fall beyond the range of this study; they suggest that the types of issues involved in the therapist's

identification with the patient may have implications which extend beyond the practice of psychodynamic psychotherapy into the practice of other types of psychotherapy, and into the administration of clinical agencies as well.

Psychodynamic psychotherapy is in many ways an ideal setting in which to study the phenomenon of identification. Unlike non-clinical social work settings, or the intra-agency settings that I have observed, psychodynamic psychotherapy provides a closely controlled environment in which the therapist has been trained, both through personal psychotherapy and education, to be extremely attentive to her own thoughts and feelings. Furthermore, the setting is often overseen by a supervisor who is trained to be attentive to those reactions of the therapist that she is not consciously aware of. Thus, the structure of psychodynamic psychotherapy is created specifically to study the types of subtle emotional reactions to patients that would occur unnoticed in non-clinical settings.

However, it is planned that the information about the phenomenon of identification that is obtained through the study of the psychotherapist's response to the patient can be used to form a foundation for studying analogous phenomena in less well controlled settings.

REVIEW OF THE LITERATURE

Nominative Definition of major theoretical terms utilized in the review

It is not possible to give precise nominal definitions of the major theoretical terms utilized in the review of the literature because these terms are not used in a completely consistent manner by the all of the writers. Indeed, the bulk of the review will focus on the similarities and differences in how the various writers make use of these terms. Nevertheless, the following glossary can serves as preliminary guide to understanding the major terms used in the review of the literature. (The terms are defined in the order in which they appear in the review of the literature. Only major terms will be defined. Terms that are used by only one or two writers will be defined within the context of the their work.)

Identification: The therapist's experience of thinking, feeling, or behaving in the same way as the patient and/or any sense in which the therapist thinks or believes that she and the patient are somehow "the same".

Empathy: The therapist's feeling of sharing the patient's feelings, or understanding how they are experiencing their feelings, on an emotional basis, while simultaneously maintaining an awareness of her separateness and differentiation from the patient.

Countertransference: Any and all of the therapist's emotional reactions to the patient. This can include the full range of

possible emotional responses, from empathy to psychotic responses.

Subjective Countertransference: A countertransference reaction which is due to a idiosyncratic emotional reaction to the patient.

Objective Countertransference: A countertransference reaction which is a realistic emotional response to the patient; a countertransference reaction which is viewed as being caused by the patient, and would be experienced by any therapist working with that patient.

Projective Identification: A special type of identification in which the therapist identifies with an aspect of the patients emotional experience that the patient is not aware of, and which may not be clearly evident in the patient's verbal communications.

Introduction and organization of chapter

The psychodynamic literature on the phenomenon of the therapist's identification with the patient grows out of ideas that were first put forth by Freud. Since then, it has evolved in two related, but somewhat different theoretical traditions. One of these has focused on issues of identification with the patient and on the role of empathy in psychotherapy. The other has conceptualized the phenomenon as a specific type of countertransference.

Another body of literature has emerged which describes the therapist's identification with the patient as it is

manifested specifically in the supervisory setting -- the parallel process. This literature overlaps, to some extent, with the literature on identification and empathy, and countertransference. Nevertheless, the literature on parallel process warrants special attention because it contains a more focused study of the phenomenon than is found in the more general literature.

This chapter will be organized in three parts:

(A) Freud's contributions

(B) A survey of the literature on identification, empathy, and countertransference.

(C) A survey of the literature on parallel process.

(D) Discussion.

(A) Freud's Contributions

The concept of countertransference was first formulated by Freud (1910). He suggests that counter-transference arises in the therapist

> as a result of the patient's influence on his unconscious feelings (p.145)

He adds that the therapist must recognize the countertransference and overcome it. In this passage it is clear that countertransference can pose serious problems for the therapist. However, the nature of these problems is unclear. Is it the fact that the patient's unconscious has influenced the therapist's unconscious feelings that constitutes the problem? Or is it rather that this influence

has not been "overcome" -- which might mean that it has not been placed under the therapist's conscious control? In either event, there is no suggestion that there is anything positive in the phenomenon.

In another paper on technique, however, Freud (1912) describes how the therapist's unconscious is utilized in the treatment in a constructive manner. He suggests that the therapist must,

> turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient. He must adjust himself to the patient as a telephone receiver is adjusted to the transmitting microphone. (Freud, 1912).

In order for this to be useful, the therapist must not only be "an approximately normal person", but he should also have undergone analysis himself in order to avoid falling prey to blind spots in his analytic perception. These blind spots can take the form of either not being able to understand what patients are saying, or, more seriously, of projecting the

> peculiarities of his own personality ... as having universal validity. (p. 117).

Freud is ambiguous in this passage as to whether the participation of the analyst's unconscious in the analytic process is primarily cognitive or emotional in nature. Although he uses the term "receptive organ" as a metaphor for how the analyst uses his unconscious, most of his accounts of

the unconscious in other places describe it as being very different than an instrument of observation. Rather, it is said to consist of impulses, defenses, and repressed memories (Freud, 1900); it is a purely emotional part of the mind that is regulated by the irrational principles of primary process. In his account of the role of the analyst's unconscious in the treatment, it would appear that Freud is describing a process in which the analyst allows her unconscious feelings to be influenced by the patient, and then observes these feelings as a source of information about the patient.

Freud does not use the term "countertransference" to describe this process. Nevertheless, the use of the analyst's unconscious feelings as a means of understanding the patient would appear to be closely related to countertransference insofar as both are related to the way in which the therapist's unconscious feelings are influenced by the patient. Despite this evident similarity, the two concepts have been treated somewhat differently, and have been discussed by different writers. Theoretical discussions of the use of the therapist's unconscious as tool for understanding the patient have evolved into discussions about the role of empathy and identification in psychotherapy. Within this tradition, countertransference continued to be viewed as an obstacle. On the other hand, some theoretical discussions about the effect of the patient on the therapist's feelings have been elaborated in the literature on objective

countertransference. In these writings, a certain class of countertransference reactions is viewed as both desirable and necessary.

Although the distinction between these two theoretical trends is not entirely clear-cut, together they can be said to represent a broad theoretical framework within which the therapist's identification with the patient has been understood and explained.

The literature on empathy and identification will be considered first.

Empathy and Identification

Fliess (1942) elaborated on Freud's idea of how the analyst uses his unconscious to understand the patient. He formulated the concept of the *trial identification*, in which the analyst introjects the patient transiently, and then projects the introject back onto the patient (p. 220). This enables the therapist to see the patient both from without (through listening and observation), and from within (by means of this transient identification.) Thus, the therapist's ability to take the patient into his mind, to experience the patient's feelings as though they were his own feelings, is a critical part of the therapeutic process.

Interestingly, Fliess describes the transient introjection of the patient as a 'danger-situation' for the therapist -- a state in which her mental health and her ability to manage the case well. Thus, the experience of

identification with the patient is stressful for the therapist -- and has the potential for getting out of control. In spite of the dangers, however, it cannot be avoided. Fliess states that

> the more conscientious the worker, the less will he be able to evade this situation or retreat from it. (p. 221)

Jung (1946), working independently (by this time) of the psychoanalytic tradition, also discussed the way in which the analyst introjects the patient's pathology. He wrote,

> The doctor by voluntarily and consciously taking over the psychic sufferings of the patient, exposes himself to the overpowering contents of the unconscious and hence also to their inductive action . . . doctor and patient thus find themselves in a relationship founded on mutual unconsciousness . . . [and] the unconscious infection brings with it a therapeutic possibility -- which should not be underestimated -- of the illness being transferred to the doctor (Jung, 1946, pp. 175-176).

Jung does not elaborate here on the therapeutic value of the illness being transferred to the doctor. However, it would appear that the rationale is similar to that suggested by Fliess; the therapist will better understand the patient

by experiencing the illness in the same way that the patient does.

Greenson (1960) describes the therapist's emotional involvement with the patient as empathy rather than identification. As with Fliess's concept of the transient identification, Greenson argues that the purpose of empathy is to temporarily experience the feelings of another person for the purpose of understanding him. In empathy, Greenson (1960) states,

> one partakes of the quality and not the degree of the feelings, the kind and not the quantity (p.228)

Although empathy is critical to the therapeutic process, empathy has its hazards in the treatment, in that the

> uncontrolled empathizers . . .tend to identify or act out or have strong instinctual reactions, all of which interfere with their ability to observe and to analyze (pp.229)

He gives an example of a therapist whose empathic understanding of the patient led not to interpretation but rather to inappropriate reassurance. The reassurance he offered was exactly the type that he had wished that his own therapist had given to him when he was dealing with similar issues.

Arlow (1963) and Beres and Arlow (1974) combined the combined the concepts of identification and empathy. They

define empathy as a special kind of identification, in which the identification is transitory (as Fliess describes it, although without reference to him); and in which the empathizer preserves his separateness from the object. They stress that empathy,

> involves only a temporary sense of oneness with the object, followed by a sense of separateness.

It is the sense of separateness that allows the therapist to think about what has transpired.

In one example, they describe how a therapist reacted to a patient's dream by having a fantasy of his own that concerned feelings that were nearly identical to those expressed in the dream. Although the therapist did not consciously understand the dream, his fantasy provided a clear image of what the patient was expressing in the dream, Thus, the therapist reached the patient's unconscious through his own unconscious. This seems to be a clear clinical example of Freud's idea that the therapist's unconscious can understand the patient's unconscious.

An unusual idea first suggested by Jacobs (1973) that is developed by Beres and Arlow (1974) is that emotion can be transmitted -- and understood, by means of identification -- through nonverbal action, especially motor activity. Some therapists report that they can penetrate the meaning of certain patient communications by repeating certain gestures

or hand motions that the patient has made. Jacobs (1991) suggests that therapist may unconsciously make movements -- kinesic responses -- that are very directly related to the content and meaning of patient communications.

In one example, the therapist realized that he was anxiously touching himself on the bone behind his ear in response to a patient discussing a recent cold. The therapist thought that this was related to the patient's anxiety about a near fatal case of mastoiditis in childhood, which had been revived by having a cold. Jacobs views these kinesic responses as an aspect of the empathic response to the patient.

Kohut (1959,1984) argues that empathy is not simply an essential element in psychotherapy, but rather that it is *the* essential element for the observation and understanding of psychological phenomena. It is only through empathy that other people can be understood at all, in terms of understanding their motivations and feelings.

Furthermore, Kohut (1984) argues that the most frequent cause of treatment failure is a failure of empathy on the part of the therapist. This suggests that the process of empathy frequently eludes the therapist's ability to control it.

Theorists who have focused on empathy have also described types of therapist identifications with patients that are non-empathic (Reich, 1960; Arlow, 1985). Reich (1960), for example, gives an example of a male therapist who tended to

fall in love with his female patients. When this was analyzed it was understood to be not a true attraction to the patients, but rather a wish to be like a woman, to have a feminine relationship with a man. The identification was based on his own wishes and fantasies about being female rather than on the experience of actually feeling his female patients' feelings. This type of identification is viewed as being the opposite of empathy, in that the therapist mistakenly takes his own feelings to be those of the patient. Cases of this type of identification are viewed by empathy theorists as countertransference, in Freud's sense of the term as a obstacle to treatment.

Summary -- Identification and Empathy

Although there are differences in the models suggested by the writers which have been discussed, there are a number of trends which run through them:

--The experience of the therapist feeling the patient's feelings as though they were her own is necessary in order to enable the therapist to understand the patient on an emotional level.

-- This process can take the form of the therapist's feeling the patient's feelings *as though* they were her own, she may experience personal feelings that are analogous to the patient's feelings, or she may experience kinesic or motor feelings that enable her to better understand the patient.

-- In order for this process to be useful, the therapist must experience the patient's feelings, and then regain her distance from them; thus, the process of experiencing the patient's feelings must be a temporary one.

-- This process can be hazardous for the therapist, both in terms of her own mental health (Fliess, 1942), and in terms of her ability to manage the case. Identifications and empathy can go out of control if the therapist experiences the feelings in too intense a form, if the therapist is unable to regain her distance from the feelings, or if the therapist is for any reason unable to separate herself from the feeling of oneness with the patient. When this situation occurs it becomes possible that the therapist will not be able to properly conduct the therapy. It is this situation that Freud (1910) and the empathy theorists refer to as countertransference.

However, other theorists have elaborated on the concept of countertransference in ways which have moved beyond Freud's initial evaluation of it and which may further illuminate the nature of the therapist's identification with the patient.

It is these various theories on objective countertransference that will be considered next.

Objective Countertransference

Ferenczi (1919) introduced the term "objective countertransference" to refer to the therapist's reactions to the patient's actual personality. Winnicott (1949), in a discussion of work with psychotic patients, further refined this idea. He argued that with certain types of patients (psychotics and those who are anti-social) there exists a

> truly objective countertransference .... the analyst's love and hate in reaction to the actual personality and behavior of the patient, based on objective observation.

To experience these feelings is crucial to understanding everything that the patient is trying to communicate to the therapist. In Winnicott's formulation, therefore, having countertransference reactions of this sort does not represent either a problem in the therapist's unconscious or any other sort of lack of awareness on the part of the therapist. Rather, it could be described as correct state of emotional attunement to the patient.

Heimann (1950) extended the discussion of countertransference to work with all types of patients. She argued that

> the analyst's emotional response represents one of the most important tools for his work (p.140).

What the therapist should be able to do is to *sustain* the feelings which are stirred in him (p.140), and thus use them as a means for understanding the patient. The countertransference is "the most dynamic way" (p.141) in which the patient's voice reaches the therapist. Although she does not make use of the term "objective countertransference", she states that,

> it is not only part and parcel of the analytic relationship, but it is the patient's *creation*, it is part of the patient's personality (p.142).

Heimann does not claim that all of the therapist's feelings about a patient should be viewed in this light, but rather that the therapist should consider the possibility that any feelings could be objective.

Racker (1953) delineated two major types of countertransference reactions (which, reminiscent of Fliess's terminology, he refers to as *identifications*) that the therapist may experience in relationship to the patient: complementary identifications and concordant identifications.

The complementary identifications are those in which the therapist becomes identified with the patient's inner objects. These correspond to the types of interpersonal emotional responses described by Winnicott (1949) and Heimann (1950).

The concordant identifications, on the other hand, are those in which the therapist identifies his ego with the

patient's ego. In this case, the therapist would experience the same feelings as the patient. This idea of the concordant identification clearly describes the therapist's experience of identifying with the patient's feelings.

Racker views empathy as a sublimated form of the positive concordant identification, a notion that suggests that the unsublimated concordant identification is a more intense, and, perhaps, a less detached sort of experience than empathy. Indeed, his account of the phenomenon is reminiscent of Fliess's (1942) account of the transitory identification as a danger situation for the therapist.

Racker (1953) noted that most discussions of countertransference had not included the experience of identifying with the patient, but that it would be more useful to include it as well. What this contributes to the theory of countertransference is the idea that intense experiences in which the therapist feels like the patient can be a product of the patient, and can be used to understand the patient.

While this is very similar to the classical discussions of empathy (eg, Greenson, 1960), it includes a wider range of the therapist's emotional responses to the patient as being within the domain of what is useful to the therapist. It differs from empathy primarily in its intensity, and perhaps its duration. It certainly does not resemble the uninvolved state prescribed by Reich (1960) as the correct form of

emotional engagement with the patient by the empathic therapist.

Searles (1955), using very different language, also described the experience of feeling the patient's feelings as an objective reaction to the patient. In one of the seminal papers on parallel process (which he referred to as the *reflection process*), he argued that the therapist's countertransference feelings were an important tool for understanding the patient (p.137). The specific type of countertransference that Searles describes in this paper is a kind of identification, in which the therapist acts in the supervision like the patient did in treatment. (His example will be discussed at greater length in the section on parallel process.) He explains it as the product of the patient's attempt to communicate feelings that he is unable to communicate directly. In a later paper, he argued that

> the countertransference gives one one's most reliable approach to the understanding of patients of whatever diagnosis. (Searles, 1986, p.190).

Since the early 1960's a number of theoreticians have adopted some form of this position that certain types of countertransference are most fruitfully viewed as objective reactions to the patient. These theorists include Spotnitz (1963, 1979), Kernberg (1965), McDougall (1979), Wolf (1979), Ogden (1982) and Bollas (1983). (This includes only the most

influential theorists, and their seminal papers.) However, the majority of the discussions have been focused on interpersonal, as opposed to identification, forms of countertransference.

One area in which identification has been a central focus is in discussions of patients who exhibit the defense mechanism of projective identification (Klien, 1946) in the treatment. The intensity of this process can be seen in Grinberg's (1962) account of it. In projective identification, the patient projects his "own conflicts, emotions, or parts into the object" (p.202). The therapist who is the object of a projective identification may react to this by counteridentifying with the part that has been projected upon him, thus experiencing it as if it were his own feeling.

He gives an example of a student therapist who had the feeling that he was 'killing himself' with a patient, through giving a lot of interpretations, none of which had any satisfactory results. He was left feeling depressed by the feeling of failure, which he later reported to his own therapist. He then listened to his therapist's interpretations, and had the impression that it was now his therapist who was 'killing himself' by trying -- but not finding -- the correct interpretations. Subsequent discussion of this interchange suggested that he had indeed counter-identified with the feelings that his patient had projected

onto him (i.e. adopted the patient's feelings as his own). This is to say, it was initially the patient who had the feeling of killing herself through repeated failing efforts. The student therapist had, in turn, projected onto his own therapist the feelings that had initially been projected onto him. (In this case, the student's own therapist was also pulled into the process, as he too had counter-identified with the student therapist's projection.)

Grinberg's description of projective identification and counteridentification contributes another sub-dimension to the typology of countertransference. In this type of experience, the therapist is experiencing a *part* of the patient's feelings, but a part which the patient may not be consciously experiencing herself. Thus, it can be described as a special type of concordant identification in which the similarity of the therapist's feeling with the patient's feelings may not be apparent until the experience has been analyzed.

The concept of countertransference due to projective identification has been further developed by Grotstien (1981) and Ogden (1979,1982), who suggest (in a manner similar to Searles (1955) that projective identification serves as a form of unconscious communication to the therapist. The therapist who allows herself to feel these identifications with the patient is permitting the communication to take place. Ogden (1982) for example, suggests that when the patient feels hopeless and helpless, the therapist often has to live with

the feeling that he is a hopeless therapist. This should be viewed as a communication that the patient feels hopeless.

Identification as a form of countertransference with specific types of patients

Kernberg (1965, 1974) has described identification types of countertransference reactions to borderline and narcissistic patients. He argues that these are the result of projective identification. With borderline patients the therapist is apt to experience very intense feeling states which may alternate quickly. With narcissistic patients the therapist is inclined to feels a sense of emptiness and deadness which is viewed as a result of the patient's projected feelings of emptiness.

Spotnitz (1985) has discussed the role of countertransference in the treatment of schizophrenic and other pre-oedipal patients. He calls this "narcissistic countertransference" -- a state which includes identifications with the patient's feelings. For example, he suggests that when the patient feels anxious or talks without affect, the therapist may feel mild anxiety or feel unmoved. Or, when the patient is in a state of self-preoccupation, the therapist may drift into a state of self-preoccupation. The therapist's feeling is exactly analogous to what the patient is feeling.

Giovacchini (1989) has extensively discussed examples of identifications within a framework that is similar to that of

projective identification. He argues that therapists can *absorb* (p. 190) a patient's ego states, thus feeling the same feelings that the patient feels. He suggests that this is prone to occur with patients who experience "inchoate psychic states" (P. 175-215), states of intense psychic tension derived from the pre-mentational period of psychic development. These states are characterized by n kind of amorphous, physiologic agitation that can be experienced by the therapist without any conscious understanding of what is occurring. These states are extremely painful, and can lead the therapist to behave in ways that are destructive to both the patient and the therapeutic process, if they are not consciously understood and controlled.

He gives the example of a patient who was treated by two different therapists. Both therapists became extremely angry with the patient and experienced an almost overpowering urge to rape her. Both were able to control themselves sufficiently to stop themselves from acting out, but were unable to continue treating the patient. Their feelings were understood as defenses against tolerating the intense state of tension that the patient was experiencing and that the therapists had absorbed. In this case, it was neither the behavior nor the conscious feelings that the therapists absorbed from the patient: rather, it was the patient's state of tension -- the tension which underlay their feelings and their behavior -- that the therapists had identified with.

Giovacchinni (1989) also describes how therapists identify with depressed patients:

> The therapist often identifies with the negative elements of the patient's reactions, his misery and hopelessness. Under these circumstances, analysts lose faith in the analytic method as they incorporate the patient's helplessness and hopelessness. (p.226)

Countertransference in the form of identification has recently been viewed as an extremely important factor in the treatment of patients suffering from various types of Post-Traumatic Stress Disorder. Wilson and Lindy (1994) suggest that overidentification with the patient is one of the major categories of countertransference that therapists who work with traumatized patients are prone to develop.

One form that this takes is the phenomenon of *vicarious traumatization* (McCann and Pearlman, 1990), in which the therapist absorbs the feeling of being traumatized herself as the traumatized patient recounts the details of her trauma. McCann and Colletti (1994) give an example in which a therapist responds to a patient's fragmented description of ritualized abuse with feelings of horror and a feeling of sickness in the stomach

> a similar place from which the material came from in her [the patient](p.111).

Kluft (1994), describing the phenomenon as it is manifested with patients with Multiple Personality Disorders, suggests that the therapist suffers from the patient's suffering. Hartman and Jackson (1994) interviewed 10 professionals from various mental health disciplines who had worked with rape victims and found that all of them

> had manifested symptoms and behaviors indicative of personal trauma . . . hyperarousal, sleep disturbances, nightmares, depression, and altered responses to the opposite sex (p.240).

These reactions were attributed to being exposed to the material that the patients described to them and were viewed, in part, as an expression of overidentification with the patients.

Similarly, stressful countertransference identifications have been described in working with war veterans who suffer from Post-Traumatic Stress Disorders who were perpetrators of violence themselves (Maxwell and Strum, 1994). The therapist may feel a form of guilt which appears to mirror the guilt of the veteran over acts of violence that were committed during the war. The authors describe a case in which the most difficult countertransference feelings for the therapist to manage were those in which he identified with the patient's having committed atrocities against civilians.

Summary -- Objective Countertransference

Theories of objective countertransference argue that some countertransference reactions are best viewed as creations of the patient (Heimann, 1950). These reactions reveal important information about the patient, and must be understood if the therapist is to understand the patient. A sub-type of objective countertransference reactions are the concordant identifications (Racker, 1957). These are the therapist's identifications with the patient's feelings. While similar to the experience of empathy, they can be more intense, more involved, and possibly more on-going than what is usually described as empathy. This type of experience would include the experience of projective identification in which the therapist feels an aspect of the patient's feelings that the patient may be unaware of himself. Some theorists argue that this experience represents an important type of communication between patient and therapist.

Countertransference, including identification with the patient, has been viewed as an important type of reaction with specific types of patients, including borderline and narcissistic patients arrested in pre-mentational states, and depressed patients, schizophrenic and pre-oedipal patients, and patients suffering from Post-traumatic stress disorder.

Discussion -- Identification, Empathy, and Countertransference

The origin of the idea that the therapist must identify in some way with the patient in order to understand him can be found in Freud's (1912) theory that the therapist uses her own unconscious as a tool for understanding the patient's unconscious. This theory has been developed in two slightly different directions by those who have described the phenomenon as empathy, and by those who have described it as a form of objective countertransference.

Theorists from these different schools view their respective theories as being antagonistic. Reich (1960), arguing from the perspective of the classical position, views the use of countertransference for understanding the patient as an inadequate substitute for empathy.

On the other hand, Epstein and Feiner (1979), arguing from the countertransference perspective, consider Reich's views to be arbitrary, mechanistic, and unempirical.

In fact, there are some significant differences between the models, the most important being that the countertransference theorists argue that some types of intense and involved emotional responses to patients provide valid and invaluable information about the patient, whereas the empathy theorists argue that such responses are indicative only of problems in the therapist.

In spite of these differences, however, there is one important point on which they agree: the therapist must, in

some important way, be able to understand the patient's feelings as though they were his own. While they differ substantially on the ideal and acceptable levels of intensity of this experience, both agree that it must occur if the therapist is to fully understand the patient on an emotional level.

Furthermore, a conclusion that can be drawn from both position's insistence that the therapist must experience some sort of identification with the patient -- however this identification may be conceptualized -- is that this process can easily go out of control. Although this aspect of the phenomenon has been emphasized more frequently by the empathy theorists, it is a central assumption of the objective countertransference theorists as well (Spotnitz, 1984). All theorists would agree that therapists must be aware of what they are feeling, and use the experience to inform, but not to interfere with, the conduct of the case.

Theorists from both positions would agree that some degree of breakdown in this process has taken place in the parallel process, when the therapist re-enacts patient behaviors, thoughts, or feelings in supervision without being conscious of it. In the literature on parallel process both types of theories have been invoked to explain the parallel process, and it is this literature that will be considered next.

Chapter 2b Parallel process

The term *parallel process* was coined by Eckstein and Wallerstein (1956) to describe the phenomenon in which a psychotherapist in supervision apparently behaves with her supervisor in the same way as her patient behaves with her. Numerous writers (Searles, 1955; Arlow, 1963; Gediman & Wolkenfeld 1980; Mayman, 1976) have commented on its ubiquity, inevitability, and universality within the supervisory process. The term has also been applied to situations in which therapists appear to adopt or imitate patient behaviors in settings outside the therapy, such as training seminars (Sachs and Shapiro, 1976) and case conferences (Sigman, 197).

The literature on parallel process overlaps, to some extent, with the literatures on identification,empathy, and countertransference in that these broader concepts are used by most writers to understand and explain the parallel process. Furthermore, examples of parallel process have been used as illustrative vignettes (although not labeled as such) in some of the seminal papers on objective countertransference (Searles, 1955) and empathy (Arlow, 1963). Thus, the phenomenon of parallel process has been conceptually entwined with the issues of empathy and countertransference ever since it was first observed.

Nevertheless, there are differences between the literature on parallel process and the literatures on

identification, empathy, and countertransference which make it useful to review them separately. Much of the literature on empathy and countertransference is focused on the therapist's experience of *feeling* like the patient, or experiencing an aspect of the patient's feelings. In contrast, the literature on parallel process tends to focus on examples of the therapist actually *acting* like the patient. Thus, parallel process would appear to describe a more intense experience than either empathy or countertransference, and one in which the similarities between the therapist and the patient are more immediately apparent than in empathy or countertransference.

Many examples given in the empathy and countertransference literature are derived from self-reports by the theoreticians themselves. Much of the literature on parallel process, on the other hand, is reported by supervisors who observed the behavior in their supervisees. Thus, the literature on parallel process adds an element of observational objectivity that is lacking in much of the literature on empathy and countertransference.

And while most writers have utilized concepts of empathy and/or countertransference in their understanding of parallel process, some have suggested additional factors which appear to be related to the occurrence of parallel process. These additional factors are useful in understanding the conditions

under which the therapist's identification with the patient goes out of control.

Finally, the literature on parallel process also contains discussions of practice issues related to the occurrence of parallel process.

Organization of Chapter

This chapter will review the theoretical and empirical literature on parallel process since it was first observed by Searles (1955). It will be organized in four parts:

1) A description of the research methods that have been used to study the process
2) A survey of the phenomenonological and theoretical issues related to parallel process
3) A survey of the practice issues related to parallel process

Research Methods

The majority of the research that has been conducted on parallel process has been done by supervisors. It has been phenomenological and theoretical in nature, and has grown out of direct clinical experience, with the supervisor serving as a participant-researcher.

There have also been two structured studies. Doehrman (1976) studied eight therapies involving two supervisors, four therapists, and eight patients. She conducted weekly and follow-up interviews with each of the supervisors, therapists, and patients. In addition, she used rating forms with the

therapists and supervisors which included some of the same questions that were asked in the interviews. These rating forms were designed to provide "a rough measure of empathy" (p. 26) and to determine if the clinical interviews alone were reliable.

Friedlander et al. (1989) conducted a single-case study utilizing a battery of twelve instruments administered in various combinations to the supervisor, therapist, and patient. These instruments were designed to provide an initial assessment of each participant (including diagnosis, supervisory style, and theoretical orientation) and process indexes of similarities in the interpersonal behaviors of patient, therapist, and supervisor.

Phenomenology

Searles (1955) was the first writer to describe the tendency of therapists in supervision to re-enact their patient's affective and behavioral states in their relationships with their supervisors. His attention was drawn to this process by his experience, as a supervisor, of having intense and often puzzling emotional responses to the therapist's presentation of clinical material. He describes a number of examples of this phenomenon.

In one example, a therapist described some poor work which he had done with his patient and then

> looked at me searchingly, as if expecting adverse criticism (p. 137).

Searles writes that he actually did feel critical of him -- unexpectedly so, in light of having known and respected him for a long time prior to supervising him. This experience was repeated in the next session, at which point the therapist mentioned that the patient was presenting "ugly material" about perverse sexuality and feces, and that he had looked "searchingly" at him.

At this point, Searles recognized the similarity between the patient's behavior and the therapist's behavior. The therapist had created in the supervisory sessions the same repellent, distancing feeling-tone that the patient had created in the therapy sessions.

From this and other examples it can be seen that Searles includes the patient, the therapist, and the supervisor within the scope of the process, which he calls the 'reflection process'. In this process, the therapist re-enacts the patient's behavior quite precisely, while the supervisor experiences the same feelings with the therapist that the therapist experienced with the patient.

Eckstein and Wallerstein (1958) coined the term parallel process to describe the apparent similarities between the therapist in supervision and the patient in therapy. In one example, the therapist and the patient appeared to be exhibiting problems with passivity -- the patient in relationship to her life and to the therapist, and the therapist in terms of his relationship to the patient and to

the supervisor. Thus, both appeared to be working on the same types of problems.

Mattinson (1975), like Searles (1955) uses the term 'reflection process' to describe what is referred to here as parallel process[1]. She gives a number of highly detailed examples of parallelisms which were drawn from social work settings -- primarily criminal probation work, and work with children and families -- which later came up in an advanced course for casework supervisors on supervision. She notes that in some cases the worker experiences a simple identification with the patient:

> The client seduces or manipulates the worker into a way of thinking, feeling, and acting like him; the worker loses his boundary and in supervision enacts the client's behavior, which has become indistinguishable from his own. (p. 44)

Examples of simple identifications can include cases in which there are more than one client, and the worker identifies with one of the clients, and the supervisor identifies with the other. In one example, a student was working with the man in a couple, and the supervisor was working with the woman. The

[1]Mattinson reports that she independently observed the phenomenon in the course of experimental training classes that were given to casework supervisors; later, after reading Searles, she found that her observations in social work practice were consistent with his observations in a psychiatric practice, and she adopted his terminology to describe it.

student related to the supervisor in the same way as the man was relating to the woman, and the supervisor related to the student in the same way as the woman related to the man.

Other manifestations of the problem can be more complex. These include cases in which the client projects a feeling and the worker accepts this feeling.

> There are many clients who cannot know about or hold big areas of their own feelings. It is the worker who comes away from the interview inappropriately worried, anxious, and overburdened. . . The client has got rid of the bad feelings and the worker is left with them. The worker may either continue to carry them in supervision, or he may, in his turn, attempt to get rid of them into the supervisor. (p.45)

Mattinson emphasizes that one of the keys to recognizing a parallelism is that it is it involves behavior which is out of character for the worker or the supervisor. However, she notes that the quality of being out of character can be very subtle. What could at first glance be dismissed simply as poor casework or poor supervision might, after analysis, be revealed as a parallelism.

Kahn (1979), Gediman and Wokenfeld (1980), Bromberg (1982), Davenport (1984), and Epstein (1986) have all described similar examples of parallel process in the context of individual supervision. Both Kahn (1979) and Davenport

(1984) have given examples derived specifically from social work settings.

Kahn (1979) gives five examples. In one case, a normally well organized and effective social worker became extremely confused by a

> depressed, poorly functioning mother [who] defied the worker's numerous attempts to help her plan an orderly life for her family and an orderly method of treatment. (p.525)

Kahn (1979) suggests that in this case that the "diffuseness, helplessness, and despair" (p. 525) experienced by the worker were absorbed during sessions with the client. In other cases described by Kahn (1979), the process was related to unresolved personal issues in the therapist, rather than the patient's dynamics.

Davenport (1984) presents an example from a family therapy case in which a teenager refused to accept her mother's rules regarding curfews and chores, and the mother is overwhelmed and exhausted. Davenport (1984) describes how the therapist is identified with the acting-out teenager, and consequently is unable to make "rational choices between the various psychotherapeutic strategies" (p. 354). She experiences the supervisor as the overwhelmed mother, and the supervisor feels herself to be identified with the mother. Resolving the problem as it was manifested in the supervision led to resolution in the therapy.

In nearly all of the examples from all settings, the therapist's behavior seems to be an exact re-enactment of the patient's behavior -- although, as Mattinson observed, the exactitude of the re-enactment is not always immediately obvious.

A number of writers have observed parallelisms operating in group supervision and training seminars as well. Sachs and Shapiro (1976) described parallelisms between the interactions in a continuous case seminar and the interactions between the therapist and his patient. Caligor (1981) and Gorkin (1987) described parallelisms in on-going group supervisory sessions.

Sigman (1989) describes three examples of parallel processes occurring in case conferences. In all cases the presenters behaved in ways that were strikingly similar to the patients that they were presenting, while the other group members or staff in attendance responded as the therapist had in the treatment. Sigman (1989) offers guidelines for identifying parallel process in a group setting. She suggests that the surest signs are when the presenter is engaging in any uncharacteristic behavior, or when what is transpiring appears to be a caricature of certain elements of the case.

The occurrence of parallel process can carry through to supervisors consulting with each other on their supervisees. Mattinson (1975) describes this occurring in her course for supervisors. Gediman and Wolkenfeld (1980) describe a group

of senior supervisors presenting their supervisees in which parallel process emerged continously.

Caligor (1981) described a parallel process of a dynamic which originated in a patient's relationship with her boyfriend, and which was then re-enacted in the therapy, the supervision, and in a supervisory peer group. All participants became affectively involved in the process.

Fulop and Schuman (1987), working within the conceptual framework of systems theory rather than psychoanalysis, describe what they call *process parallels* on a hospital ward. In these examples, dynamics which originated in a ward community meeting were re-enacted in both a training seminar and in an administrative meeting. They note that these types of re-enactments have been noticed frequently by systems theorists.

While most studies of parallel process have involved unplanned anecdotal reporting, two have approached the study more systematically. Doberman (1976) conducted a structured study which combined in-depth interviews with patients, therapists, and supervisors with the use of quantitative scales. She found some evidence of therapists behaving towards their supervisors as their patients had behaved towards them.

Friedlander et al. (1989) conducted a study which documents the presence of parallel process in an eight session psychotherapy. Their research measured consciously reported

attitudes well as other aspects of the relationships which were measurable; their instruments did not measure unconscious processes, such as identifications, and they do not speculate about such processes. They found a striking degree of similarity in the extent to which the patient valued the therapy sessions and the therapist valued the supervisory sessions. There were also significant similarities in the styles of verbal communication, the supportiveness of the sessions, and the lack of conflict in each of the relationships.

Theories of identification, empathy, and countertransference as explanations of parallel process

A number of writers have discussed the role of identification, empathy, and countertransference in parallel process. These writers fall into two main positions on the subject. The first group argues that the dynamics that are re-created in the parallel process are the patient's dynamics, and are best understood as being caused by the patient's pathology. The second group suggests that the dynamics re-created in the parallel process only *look* like the patient's dynamics; in fact, the process is best understood as an expression of the therapist's pathology. Each position will be examined in turn.

The first position may be described as the patient-centered explanation of parallel process. Searles (1955), Arlow 1963, Gediman and Wolkenfeld (1980), Gorkin (1987), and

Epstein (1989) are the principal exponents of the first position. Searles (1959) Arlow (1963), and Mattinson (1975) have offered the most developed theories.

Searles (1955) suggests, in a manner reminiscent of Fliess (1942), that the process occurs as the result of an unconscious identification by the therapist with the patient which is transitory in nature. However, the therapist is unable to articulate the nature of this identification to the supervisor. Thus, the process serves an important communication function in the supervision:

> It is as if the therapist were unconsciously trying, in this fashion, to tell the supervisor what the therapeutic problem is. (p.144).

The therapist is merely a passive channel for the patient's dynamics, allowing the supervisor a relatively undistorted view of what is occurring in the treatment. The therapist's personal dynamics play only a minor role in the process - that of a conductor. Searles conceptualizes this sort of identification as a countertransference reaction, and views it in a positive light.

Similarly, Arlow's (1963) explanation of this phenomenon is that it is the result of a transitory identification with the patient, also in a manner reminiscent of Fliess (1946). This kind of identification is a normal and necessary part of the analysis. In therapy

> the therapist oscillates between identifying with the patient and observing him. During supervision he recapitulates the oscillation of roles (p. 579).

He relates this to Greenson's (1960) ideas about empathy as a kind of sharing of the emotional impact with the patient's experience. The process is an outgrowth of the therapist's empathy. Furthermore, the supervisor empathizes with both the therapist and the patients, and also experiences these transitory identifications. Thus, the transient identifications which lead to parallel process pervade the all areas of the therapeutic relationship.

As with Searles (1955), Arlow views the process as a kind of communication, stating (in connection with a different example) that a patient's hypomania had, in part,

> eluded the therapist, but he had nonetheless placed [it] in the record by acting out an identification. What he failed to remember, he had repeated (p. 580).

He differs from Searles, however, in that he does not view the process as an example of countertransference. In his view, empathy is both expectable and useful in the treatment, whereas countertransference is a source of interference.

Mattinson (1975) argues that the identification can grow out of the therapist's attempt to describe to the supervisor

what is not fully understood by the patient. This takes place through mimicry.

> One way of describing is to mimic, particularly for vividness, and particularly if we cannot find adequate words to portray the phenomenon. . . . In his [the therapist's] attempt to describe what he cannot put into words, he unconsciously mimics (p. 43-44)

In Mattinson's view, the identification in parallel process can be a simple one, or it can be an identification with only a part of the patient's feelings, those that the patient would prefer to disown. Although Mattinson does not use the term projective identification to describe this latter type of identification, her idea is very similar to this.

Gediman and Wolkenfeld (1980) agree that both therapy and supervision depend on identification processes in order to be effective, and that these identification processes partially account for the occurrence of parallel process. In addition, they stress other "structural and dynamic similarities of psychoanalysis and supervision" (p. 241); these similarities "establish the conditions for multidirectional parallel re-enactments" (p. 254).

Gorkin's (1987) analysis of an example of parallel process in a group supervisory setting involved the concept of projective identification:

> both patient and therapist employed the mechanism of projective identification not only for ridding themselves of a stressful part of self/and or introject, but also for the purpose of communication (p. 230).

Eckstein and Wallerstein (1956), Bromberg (1982), and Lawner (1989) are the principal authors of the therapist centered explanation of parallel process. While they agree that identification is an essential component in parallel processes, they view this type of identification primarily as an expression of defensiveness on the part of the therapist. As such, it is a rather different phenomenon than the transient identifications and empathy that are viewed as being crucial to the therapeutic process.

Lawner (1989) specifically challenges Searles contention that the therapist is somehow

> not essentially complicit in what is occurring, but is serving as an auxiliary messenger (p. 595)

of the patient's pathology. Rather, Eckstein and Wallerstein (1956), Bromberg (1982), Davenport (1984) and Lawner (1989) view the process primarily as an expression of the therapist's pathology. Eckstein and Wallerstein argue that aspects of the therapist's character prevent them from relating therapeutically to the patient on a particular issue, and that these aspects of her character are expressed in the parallel

process. Davenport offers a number of examples of parallel process explained in this way in a social work setting.

> Lawner (1989) argues that parallel process is a counteridentification . . . [a] therapist authored, defensive, and (unless resolved) countertherapeutic process in which the therapist behaves in a manner analogous to that which he observes in his patient (p.597).

It is as though the therapist is masquerading as the patient, for defensive purposes of his own. Thus, what superficially appears to be an identification with the patient is actually a defense against understanding what the patient is communicating to the therapist.

The dichotomy of the patient-centered position and the therapist-centered position corresponds rather closely to the two main positions that have been formulated on countertransference: the objective countertransference theories and the classical theories. The therapist-centered position is consistent with the theories of objective countertransference, in that the therapist's emotional reaction is viewed as being caused by the patient's pathology. The patient-centered position on parallel process is consistent with the classical position on countertransference, in that the therapist's emotional reactions are viewed as being caused by the therapist's pathology.

In addition to these two main explanations, some writers have suggested that there are actually different types of parallel process, with different explanations for each. Arlow (1963; 1986) for example, who formulated one of the most complete explanations of the patient-centered position, also gives examples of parallel process which appear to be therapist- centered. Kahn (1979) was the only writer to specifically give examples of both types of parallel process, with explanations specific to each type.

Other theories of parallel process

Kadushin (1985), in the social work literature, accounts for parallel process through systems theory rather than through identification, empathy, or countertransference. He argues that a parallel process is an

> explification of isomorphism -- the tendency for patterns to repeat at all levels of the system. (204)

This idea is consistent with the ideas of Marohn (1969) and Fulop and Schuman (1987).

Factors which facilitate the occurrence of the process

A number have writers have discussed other factors which, in addition to the processes of identification, empathy, and countertransference, appear to facilitate or cause the occurrence of parallel process.

Therapist's amount of professional experience

There is considerable disagreement in the literature as to whether the amount of professional experience that the therapist has is an important factor. Searles (1956) and Gediman and Wokenfeld (1980) explicitly reject the idea that the therapist's degree of experience is a significant factor in the occurrence of parallel process. This position is also implicit in the work of Arlow (1963), Gorkin (1987) and Caligor (1981).

On the other hand, Eckstein and Wallerstein (1956), Sachs and Shapiro (1976), and Nadler (1976) all suggest that the process is more likely to occur in novices. Eckstein and Wallerstein (1956) relate it to the beginning therapist's lack of self awareness. Similarly, Nadler (1976) suggests the process occurs most commonly in

> paramedical personnel and others who have not had a chance to experience therapeutic technique in the context of a personal training analysis (p. 146).

Specific points in the therapy

One of the other factors that has been considered relevant to the occurrence of the process is the nature of the material that the patient is working on in the therapy. Searles (1955) suggests that the process is most likely to occur when the therapy is touching on some aspect of the patient's personality that is disassociated or repressed, but

close to awareness; the patient experiences feelings and anxieties but also a defense against them. It is this aspect of the patient's dynamics that sets the process in motion, by arousing similar anxieties and defenses in a similar area of the therapist's personality.

Mattinson (1975) largely agrees with Searles's ideas on the role of disassociated feelings, but argues further that disassociated feelings which are far from the client's awareness can come into the process. She also suggests that the process occurs primarily when the worker cannot find the words to explain what he experienced with the client.

Sachs and Shapiro (1976) suggest that this process occurs in novice therapists regularly at difficult points in the therapy when the therapist is

> faced with a situation that he did not understand or there was difficulty because of some technical difficulty

In particular, it occurred at the beginning stages of treatment, at points which

> involved aspects of setting up and maintaining a treatment situation so that a therapeutic process could get started.

Caligor (1981) argues that parallel process is always a part of the supervisory relationship, but that it appears most dramatically at points in the treatment where the patient, therapist, and supervisor have a crossing of blind spots and

heightened anxiety. Although each participant had his own particular intrapsychic conflicts which led them to respond in the way that they did, he differentiates this kind of a reaction from a countertransference: in a countertransference each person responds in his own unique way, while in a parallel process

> unique and disparate persons all are evoked to respond in a similar and uncritical way (p. 23)

It should be noted that Caligor is referring here to countertransference viewed from the classical position as an idiosyncratic, subjective reaction on the part of the therapist. However, his view of parallel process is consistent with it being an expression of objective countertransference, in that the fact that each participant reacts in a similar way suggests that the reaction is an objective response to the patient.

Davenport (1984) and Lawner (1989) both suggest that the parallel process occurs when the issue that is being discussed in the treatment touches on an area of the therapist's character that is in conflict. Lawner (1989) argues that parallel process occurs at points in the treatment when the patient advances a resistance which is somehow threatening to the analyst, and the analyst then responds in a defensive way

> so as to forestall the perspective expansion, deepening, and unfolding of their [the therapeutic] relationship (p. 605).

The therapist re-enacts the patient's behavior with the supervisor, and also enacts an analogous defensiveness with the patient. These behaviors are different aspects of the same problem.

Commonalities between therapist and supervisor

Many writers have suggested that similarities between patient and therapist are significant factors in the occurrence of parallel process. However, the role that these similarities play in the process has been viewed in a number of different ways.

Ekstein and Wallerstein (1958) suggest that while the therapist and the patient may, in fact, share some of the same problems, this is not a necessary component of the process. Indeed, Ekstein and Wallerstein suggest that the parallel may be more of an appearance than an actuality when they state that

> therapist and patient *seem* (emphasis added) to be constantly working on the same problems (p.177).

They see the mechanism of parallel process as lying in the fact that the

> beginning therapist selects the patient's material, distilling it through the vehicle of the emphasis dictated by his own needs (p.179).

Thus, the therapist is inclined to focus on those aspects of the patient's pathology which most closely touches on their

own. In a sense, the therapist is unconsciously using the patient's material to describe his own issues.

Other writers, however, suggest that the similarities between patient and therapist are in fact real. Arlow (1963) suggests that examples of therapist's acting like the patient "demonstrate how therapist and patient may share certain fantasy wishes in common" (p. 582). Sachs and Shapiro (1976) suggest that there are

> some general similarities among narcissistically vulnerable novices which, in turn, are congruent with anxieties found in most patients with regard to feelings of inadequacy, dependency, authority as a protection against helplessness, etc. (p 410).

From this perspective, the patient's anxieties arouse similar anxieties in the beginning therapist. Kahn (1979) describes examples in which real similarities between the patient's pathology and the therapist's pathology were viewed as significant factors in the process.

Searles (1955) approaches the question of commonalities between therapist and patient from a different angle. On the one hand he suggests that the patient's dissociated anxieties arouse anxieties from a similar part of the supervisees personality. On the other hand he argues that the therapist acts primarily as a conductor of the patient's dynamics, and that his own dynamics are relatively unimportant in the

process. This suggests that there are real commonalities between patient and therapist, but that these commonalities are of a universal, as opposed to a particular sort. It is not the similarities between the unique and individual characteristics of the therapist and those of the patient that are most relevant to the process, but rather the general similarities are shared by most therapists with most patients insofar as they are common human experiences. This is reminiscent of Freud's (1910) idea that the analyst's unconscious can understand the patient's unconscious because everyone's unconscious operates according to the same principles The understanding of the role of commonalities in parallel process is shared by most theorists who adhere to the patient centered position on parallel process

Factors in the supervision

Some writers view the occurrence of parallel process as being rooted in the supervisory relationship rather than in the therapy relationship.

Nadler (1976) suggests that the process arises in supervision when the supervisor does not meet the needs of the "relatively untrained" therapist. Although Nadler sees problems in the supervision as being causative in the process, it should be noted that once the process occurs, the feelings or behavior which are re-enacted are those of that patient, and Nadler's understanding of the process is patient-centered.

Bromberg (1982) also sees the supervisory relationship as key to the emergence of parallel process, but views it from the therapist centered position. He suggests that the causative factor is the therapist's unconscious need to keep certain aspects of his character outside of his relationship with the supervisor. Bromberg describes a therapist (it is not clear from his work whether this is an actual vignette, or a hypothetical example) who becomes domineering towards a patient with whom he has been having difficulty. Later, while reporting the incident to the supervisor, the therapist becomes a caricature of deference, while the supervisor becomes increasingly authoritarian in his tone. Bromberg suggests that therapist uses the identification with the patient's defense as a means to disown his own aggressiveness, to hide it from the supervisor. The identification with the patient, is therefore, "a very powerful aspect that must not be overlooked, but is not primary to the phenomena" (p. 108). Thus, neither patient dynamics nor the therapeutic relationship with the patient are the causative factor in the process.

Summary -- Phenomenological and Theoretical Issues in Parallel Process

Parallel process has been observed in a wide range of settings, including individual supervision, supervisory groups, case presentations, administrative meetings, and supervisory peer groups.

A number of writers have related the occurrence of parallel process to the phenomena of identification, empathy, and countertransference. There have been two major positions on this. Those who hold to the patient oriented position suggest that the therapist's identification with the patient is the major factor in the occurrence of parallel process, and view the therapist's own pathology as playing an unimportant role in the process. In contrast, those who hold to the therapist-centered position argue that the therapist adopts the patient's behavior out of her own defensive needs. The identification does not grow out of the therapist's understanding of the patient, but out of the therapist's own psychopathology.

In addition to the therapist's identification with the patient and related phenomena, other factors have been described as fostering the occurrence of parallel process. These include the amount of experience and/or training that the therapist has had, specific phases in the treatment, the quality of the supervision, and real commonalities between the therapist and the patient. There is no consensus on the relative importance of the any of these factors.

Practice Issues

There is a general consensus in the literature that parallel process is usually an important phenomenon to be dealt with in supervision. The patient-oriented theorists, including Searles (1955), Mattinson (1975) Nadler (1979),

Gediman and Wolkenfeld (1980), and Gorkin (1987), all view the process as an extremely important source of information about the patient. It is material that the therapist was unable to consciously understand, but was able, through the re-enactment, to bring into the supervision.

On the other hand, therapist-oriented theorists, including Eckstein and Wallerstein (1956), Bromberg (1982), Davenport (1984) and Lawner (1989) view it as an important obstacle to either the progress of the supervision or the progress of the therapy, and thus as a significant issue to be addressed.

In addition, writers who do not specifically address the question of whether the parallel process should be understood as being patient-centered or therapist-centered, such as Caligor (1981), and Loganbill et al (1982), agree that parallel process is an extremely important phenomenon to address within supervision. Loganbill, Hardy, and Delworth (1982) argue that,

> an understanding of the phenomenon of parallel process can provide the basis for some of the most potent interventions and conceptualizations within supervision (p. 30).

The main issue, therefore, is how the process should be addressed, and on this issue there is little consensus.

Arlow (1963) is the only writer mentioned who does not find it necessary to address the issue of parallelisms in the

supervisory process beyond simply observing them silently to himself. While the process does seem to represent some sort of mistake on the part of the therapist, at a point where a therapist

> should have introduced and interpretation, he responded with an identification (p.581)

However, it is an error that can usually be managed without any direct intervention by the supervisor. Instead, supervision is an opportunity to re-experience the original emotions of the experience with the patient in a "diluted dosage" (p. 590), with the supervisor serving as a kind of audience. This apparently resolves the problem that the therapist is having with the patient in a "constructive, ego-syntonic fashion."

In contrast with Arlow (1963), Searles (1955) suggests that the supervisor's feelings and observations should serve as the basis for comments about the patient. However, his approach might be described as being indirect, in that he does not generally confront the therapist with the similarity between her behavior and the patient's behavior. Although he does give one example in which confronting the similarity directly led to a significant improvement in the supervisory relationship, he found that confrontation usually fostered self-consciousness and defensiveness in the therapist. Consistent with his patient-focused model, he argues that comments to the therapist should be focused on the patient's

dynamics, and not on the therapist's identification with the patient.

A number of theorists suggest that the process can be dealt with indirectly through role modeling. Like Searles (1955), Nadler (1976) suggests that the occurrence of the process need not always be identified or labeled in order to be resolved. Nadler suggests that if the supervisor treats the therapist as the patient should be treated, the therapist will then carry this over into the treatment. This is a kind of role modeling which includes interventions such as limit-setting and limited gratification of demands.

Mattinson (1975) places a high value on the parallel process. She argues that it is often necessary for the treatment for the worker to be drawn in or even collude with the client in order to reach a deeper understanding of the client's emotional situation. She encourages discussion of the worker's countertransference reactions, and also suggests that supervisors share their own emotional reactions to the case with the worker. The supervisor is often able to describe in words the feelings underling those aspects of the client that the worker has been mimicking. However, she suggests that all of this be done carefully, and the stress should be placed on using the information to understand the client.

Nadler (1976), Kahn (1979), and Gorkin (1987) all stress the need to begin relating to the therapist "*not* in this

parallel pattern" (Gorkin, 1987,p. 228), so that the flow from supervisor to therapist to patient would become a benevolent process (Doehrman, 1976). Epstein (1986) gives an example of this type of approach, responding to the therapist with very different feelings than those that had been re-created in the supervision through the parallel process.

Ekstein and Wallerstein (1958), address the issues that they perceive to be underlying the apparent parallelism directly with the therapist. However, they do not intervene immediately. In most of the cases they allow the process to evolve slowly over time, waiting until the problem is in the forefront of the therapist's mind before clarifying or interpreting it. They argue that the therapist must be affectively engaged in the supervision in order for the learning process to be effective.

Doehrman (1976) suggests that

> supervision entails the supervisor's addressing himself to the student's emotional problems which block his functioning as a therapist (p. 79).

In the course of her structured qualitative study she found that improvement of the problem in supervision led directly to improvement in the therapy. Thus, she advocates a direct confrontational approach to addressing parallelisms as they arise.

Sachs and Shapiro (1976) also take a confrontational approach to parallelisms, pointing them out to the therapist as soon as they are identified. They explain to the therapist that the identification actually impedes the therapist's empathy, in that it blocks him from achieving insight into the patient's emotional problem. They interpret the dynamic that is taking place in the supervision, and this, in turn, enables the therapist to interpret the dynamic to the therapist.

Consistent with Searles' (1955) observation, Sachs and Shapiro (1976) note that therapists do become defensive when the parallel process is identified directly. Most therapists objected to the idea that identifying with the patient was a necessary part of the treatment, and most responded to the interpretation as though they were being told that they had a countertransference that was interfering with their ability to manage the case. Sachs and Shapiro take an educative approach to this belief, pointing out the necessity of the identification process to the therapy but also the need to be aware of it so that one can interpret rather than simply re-enact.

Davenport (1984) agrees with Ekstein and Wallerstein that the therapist must be affectively engaged in the supervisory relationship in order for the parallelism to be resolved, adding that this also requires the emotional participation of the supervisor. She describes a kind of role-playing in which the supervisor shares the feelings that are aroused in her by

the therapist's behavior. This in turn moves the therapist to reflect on the feelings underlying her behavior, and to recognize the role of her character in creating the parallelism and in blocking her effectiveness as a therapist. Davenport (1984) suggests that it is important that this process not be transformed into personal psychotherapy for the therapist. Rather, the supervisor must keep the interaction focused on the therapist's work with the patient.

Lawner (1989) takes a direct, confrontive approach to the process when it arises in supervision, interpreting the defensive functioning of both the therapist and the patient, and working towards an understanding of the underlying anxieties which have been concealed by these defenses. Unlike Searles (1955) and Sachs and Shapiro (1976), Lawner states that therapists are able to utilize such an approach without becoming defensive, adding that they acquire insight into themselves as a result of the experience.

McNeill and Worthen (1989) were the only writers to consider the relevance of the therapist's level of training to the use of parallel process oriented interventions. They suggest that intermediate-and advanced-level students may be more able to make use of parallel process oriented interventions than beginning-level students. However, they add that an overemphasis on parallel process or on the relationship aspects of supervision can be wearisome for students at all levels of training.

Summary -- Practice aspects of parallel process

There is a general consensus in the literature that parallel process is a an important phenomenon to be addressed in supervision. For patient-oriented theorists it is a significant source of information to be explored, while for therapist-oriented theorists it is a significant problem to be resolved.

The main practice question is how parallel process should be managed in the supervision. And on this question there is no consensus. A continuum of opinion exists on this question, ranging from the idea that the process need not be directly addressed with the therapist at all, to the idea that the process should be pointed out directly and confrontively as soon as it occurs. Some argue that direct confrontation of the parallel process leads to a non-productive defensiveness on the part of the therapist, while others counter that the confrontation can help the therapist to obtain self-understanding. A number of theorists suggest the use of some sort of role modeling to help the therapist understand how the patient needs to be related to.

Discussion -- Identification, Empathy, and Countertransference in relationship to parallel process.

The literature on identification, empathy, and countertransference all suggests that the therapist's identification with the patient is a significant part of the psychotherapeutic process in two ways: First, the identification is a necessary component of the treatment if the therapist is to fully understand the patient; second, the failure to manage the experience of identification properly can lead the therapist to lose control of the therapeutic process.

The literature on parallel process demonstrates that the therapist's identification with the patient is not limited to the therapist's contact with the patient, but can be manifested in the supervisory process, in training and supervisory groups, in case presentations, and in administrative meetings. While it is an essential element of the therapy, its effects can be observed in many areas that are not directly involved in patient contact. Furthermore, the literature on parallel process illustrates that the therapist's identification with the patient is not limited to feeling the patient's feelings, but that it can be readily expressed in the therapist's actually behaving like the patient, without any conscious awareness that this is taking place. In fact, in none of the examples of parallel process in the literature was the therapist able to spontaneously

recognize and control what was occurring, without the assistance of the supervisor. Thus, the literature on parallel process demonstrates that the therapist's identification with the patient is a powerful force that has a significant impact on the psychotherapist -- a force that can easily elude the therapist's conscious awareness and conscious control.

Gaps in the literature

While the literature on empathy, identification, and countertransference all argues the need for the therapist to identify with the patient, the descriptions of the phenomenon have been somewhat scarce. Theoretical accounts of the phenomenon abound, yet there is little description of what the phenomenon actually looks like in reality. Although numerous anecdotal descriptions can be found, they are primarily used to illustrate theoretical and prescriptive points. There is no fully developed description of how the phenomenon is actually experienced by a number of therapists.

In general, the literature on all of these topics lacks an exploratory, research oriented focus.

Without such a focus, attempts by therapists and supervisors to identify the phenomenon as it arises in clinical practice may be limited to examples which resemble the relatively small sample of anecdotal reports that are found in the literature.

Furthermore, the lack of a more complete exploration of how the phenomenon is manifested across a range of therapists also suggests that theoretical formulations about it are based on an extremely limited set of data. Teh present study was designed to provide a richer data set that might serve as the basis for a more comprehensive theoretical account of the phenomenon.

Conclusion

The concepts of identification, empathy, and countertransference provide the broad parameters for understanding the phenomenon of the therapist's identification with the patient. Furthermore, the literature on parallel process provides a vivid account of how this phenomenon can be manifested within supervision. However, the lack of an exploratory research oriented focus in the literature imposes certain limitations in understanding the phenomenon.

It is the need to obtain a richer set of data on this phenomenon, both for the purposes of clinical utility and theoretical development, that this study was designed to address.

INTELLECTUAL FRAMEWORK

The primary intellectual framework that this study utilized is that of psychoanalytic theory. Although the phenomenon of the therapist's identification with the patient has been observed and described in other theoretical traditions (for example, Marohn [1987], in systems theory), the most fully developed accounts are found in psychoanalytic theory. Furthermore, the other major concepts that have been utilized to elucidate the nature of this phenomenon -- identification, empathy, and countertransference -- are also drawn from psychoanalytic theory.

However, while psychoanalytic theory provided the theoretical background and conceptual underpinnings of this study, it must be emphasized that neither the focus nor the methodology of the study itself was psychoanalytic in nature. A psychoanalytic study would focus on the intra-psychic aspects of the phenomenon; this study, in contrast, focused on therapists' experiences of the phenomenon, and their understanding of their experiences.

Goals

The goal of this study was to describe how the therapist's identification with the patient is actually experienced by psychotherapists in all of the settings in which it is manifested, including the therapy, the supervisory process, and the therapist's personal life outside the therapy.

The study describes examples that are in-control and out-of-control, subtle and overt, beneficial and destructive, chronic and acute, in order to portray as full a range of the phenomenon as is possible.

The study was designed to capture the type of information that will enable psychotherapists, clinical supervisors, and teachers to better identify, utilize, and control the phenomenon. The focus throughout the study, therefore, is primarily on clinical utility.

Definitions

Nominal Definitions

Therapist's identification with the patient: For the purposes of this study, this term will be nominally defined as the therapist's experiences of feeling, thinking, behaving, communicating or relating to others in ways that are clearly similar to the patient's ways of feeling, thinking, behaving, or relating. It should be noted that the therapist may or may not be aware of or conscious that this process is occurring.

This study will focus on those examples of similarity between therapist and patient which are both characteristic of the therapist's habitual mode of functioning, and uncharacteristic of the therapist's habitual mode of functioning. Both types of identifications have been identified in the literature.

In-control identification: For the purposes of this study, an identification will be defined as being *in-control*

if the therapist is consciously aware of the identification taking place; and if her behavior with the patient, the supervisor, or her outside life is not influenced by the identification unless she has made a conscious and deliberate decision to do so. *Out-of-control identification*; For the purposes of this study, an identification will be described as *out-of-control* if the therapist is not conscious or aware that the identification is taking place, or if her behavior with the patient, the supervisor, or her outside life is influenced by the identification in ways that she has not consciously and deliberately decided to do

General operational parameters of the phenomenon

As this study will be exploratory in nature, the definitions of the phenomenon could not be precisely operationalized at the onset, as this would have prematurely foreclosed the process of discovery inherent in qualitative research. The general parameters that framed the initial interviewing, however, were specified. They are defined below, accompanied by illustrations:

1) *Feeling like the patient:* The therapist has a feeling which is similar to or clearly analogous to a feeling that the patient has. Examples: The patient is feeling in despair about his career, and is unable to imagine means of becoming successful. Upon hearing this, the therapist feels despair about his ability to help the patient. Or, the therapist feels despair about his own career.

2) *Thinking like the patient:* The therapist thinks in a similar or clearly analogous way to the way the patient thinks. Examples: The patient is paralyzed in making decisions because he can never be sure what the right choice would be. He weighs every option over and over again. The therapist becomes unable to make interventions with the patient, because he is undecided over what the right intervention is. Or, the therapist finds that he is having trouble making decisions in his outside life.

3) *Behaving like the patient* The therapist behaves in a similar or clearly analogous way as the patient. Examples: The patient forgets to pay the therapist. The therapist forgets to pay the supervisor. Or, the patient is abusive to the therapist, and the therapist becomes abusive to the patient or to the supervisor.

4) *Communicating like the patient* The therapist uses language, inflections, accents, or gestures in ways that are similar to or clearly analogous to the patient. Examples: The patient uses highly intellectualized language to describe her feelings, and the therapist responds by using a lot of technical jargon in her interventions. Or, the patient's language is vague, diffuse, and full of slang and cliches. After the session, the therapist uses similarly vague language filled with cliches in talking to a friend.

5) *Relating to others like the patient* The therapist interacts with another person or people in ways that are

similar to or clearly analogous to how the patient interacts with the therapist, or to other people in his life. Examples: The patient attempts to bully the therapist into changing the time of the next appointment by talking forcefully and contemptuously. The therapist, while discussing the problem with the supervisor, becomes insistent that the supervisor give him a solution immediately, and is dismissive and contemptuous when the supervisor fails to comply.

It must be emphasized that these examples were intended only to provide a rough indication of the type of material that was sought out in the interviewing process. Not all of these examples were found in the interview material, and other types of examples -- including some which were not as immediately obvious -- emerged in the course of the interview process.

In-control identification: An in-control identification is one in which the therapist is aware of and understands that an identification is taking place. For example, a therapist who is working with a depressed patient becomes depressed herself. However, she is aware that this feeling is the result of an identification. She does not feel depressed after the session is over, she does not relate in a depressed way to her supervisor or to anyone in her outside life as a result of contact with the patient.

Out-of control identification: An out-of-control identification is one in which the therapist is either unaware

that an identification is taking place and/or is involuntarily influenced by the identification. For example, a therapist might become depressed while working with a depressed patient, but not understand the relationship of her feelings to the patient. Or, the patient might recognize the origin of the feeling, but be unable to control it and either feel overwhelmed by it in her outside life, or relate to others in a depressed manner.

Choice of Methods

Selection of qualitative methodology

This study was qualitative and exploratory in nature. Qualitative methods were selected for a number of reasons. First, the phenomenon of the psychotherapist adopting patient modes of functioning is an unclear and unexplored area of psychotherapeutic practice. Anecdotal accounts of the phenomenon by supervisors are numerous, but they are focused only on its most easily observable aspects. Similarly, anecdotal reports by therapists themselves are available, but these are often used to illustrate theoretical points rather than to fully describe the experience.

At the present time, therefore, knowledge about this phenomenon is not sufficient to adequately describe either its nature, scope, or dimensions. Without this basic level of knowledge having been accumulated, it is not possible to identify variables with any degree of precision, to formulate testable hypotheses, or to draw careful inferences.

Furthermore, the large number of different explanations that have been advanced in the current literature suggest that at the present time, the phenomenon cannot be conceptualized in a simple causal scheme. Rather, it should be viewed as a complex and fluid process. In light of the current state of knowledge about this area, therefore, quantitative methods would not have been an applicable research modality.

Qualitative methods were especially applicable to this topic because what is being sought out is not a description of observable behavior, but rather an account of the internal experience of psychotherapists who experience this phenomenon. The goal of the study was neither to test hypotheses nor to measure the phenomenon, but rather to describe, in as detailed a manner as possible, the general trends of common experience among psychotherapists who have experienced it. Qualitative methods, which are

> oriented towards exploration, discovery, and inductive logic (Patton, 1990, p. 44)

are well adapted this goal. It was hoped that an inductive analysis of the data would serve as the groundwork for the identification of variables which can later be studied within a quantitative framework.

Qualitative research methods are also called for by the nature of the data. The therapist's identification with the patient is an elusive, almost shadowy phenomenon which is difficult to observe or describe. In part, this is because

the therapist is often not fully aware of it, either at the time that it is occurring, or even afterward. The literature on empathy gives a number of examples (eg. Greenson, 1960) in which the therapist is not aware of the occurrence of an unconscious identification with the patient during the sessions. Often awareness of the phenomenon only occurs after the interchange with the patient has taken place. Similarly, the literature on parallel process is filled with examples of therapists re-enacting patient behavior with no awareness whatsoever that it is occurring.

These examples illustrate that a significant amount of this phenomenon occurs without any conscious awareness on the part of the therapist that it is occurring at the time. The therapist's understanding of the experience often relies on retrospective analysis, and her memory of it may include only a small fraction of the total experience.

While this aspect of the experience clearly imposes limits on how thoroughly the phenomenon can be explored or understood, the fragmentary memories that therapists are able to collect of the experience remain the foundation for our knowledge of it. Data of this sort are not, at the current time, accessible through quantitative methods. Only qualitative interviewing can capture them.

Choice of a phenomenological approach

This study made use of a phenomenological approach to qualitative interviewing.

The choice of the specific style of qualitative approach was based primarily on the nature of the material to be explored. Although the literature on empathy, countertransference, and parallel process offers broad clues about the nature of this phenomenon, far more exploratory work is necessary in order to begin to chart even its broadest parameters. While the literature on parallel process demonstrates that the identification with the patient can be observed by supervisors when it is manifested in the therapist's overt behavior, it is only the overt behavior that can be observed. The therapist's inner experience can be explored only by asking the therapist herself about it.

Furthermore, even in cases where the therapist is aware of the nature of the identification, its manifestations can be extremely subtle and profoundly internal. For example, Beres and Arlow (1974) describe a case in which patient reported a dream that the therapist did not consciously understand. Upon hearing the dream, however, the therapist had a fantasy that contained feelings that were nearly identical to those feelings that were expressed in the patient's dream. Once the therapist understood his own fantasy, he understood the patient's dream. Thus, he was able

to reach the meaning of the patient's unconscious communication through the use of his own personal fantasy.

This illustrates just one example of an aspect of certain types of identifications which cannot be observed. Only a methodology which utilizes an in-depth interviewing process can capture the complexity and the subtlety of this kind of experience.

Furthermore, this example also illustrates how internal experiences of this kind are intrinsically fused with the therapist's interpretation of the experience. A non-psychoanalytically oriented therapist, for example, might not have seen any connection between the patient's dream and his own analogous fantasy, or might not even have viewed it as an experience that was worthy of noting.

This research will attempt to capture these two separate, but closely inter-connected aspects of the phenomenon: the therapist's raw experience of adopting a patient mode of functioning, and his interpretation of the meaning of this phenomenon.

In view of these considerations, a number of styles of qualitative research -- including ethnographic, ethnomethodological, symbolic interactionist, systems theories, hermeneutics, and chaos theories -- were excluded from the start because they are not adapted specifically to an in-depth exploration of the individual's personal

experience. (All information on the various styles of qualitative research is drawn from Patton [1990, pp.64-91].)

On the other hand, phenomenological, heuristic, and orientational styles of qualitatitive research did seem well adapted to this type of data. An orientational approach, in which the ideological framework of psychoanalysis was used to analyze the data was rejected as being inconsistent with the exploratory nature of the research; the goal of the study is to describe the phenomenon, not to demonstrate the utility of psychoanalytic conceptualizations in illuminating it. Thus, a purely orientational approach would have diverted the study from its primarily goal of exploration of the phenomenon.

Furthermore, it should be noted that since all subjects will be psychoanalytically oriented in their clinical work (see *Sampling Strategy*), to have further applied a psychoanalytic framework to the analysis of the data appeared both redundant and theory bound.

A heuristic approach was seriously considered, in light of the fact that I (the researcher) have had extensive experience with the phenomenon as a clinician, supervisor, and teacher. In some ways, it seemed to be a logical choice to use the study to compare my own experiences to those of others.

However, it was just because I had such extensive experience with the phenomenon that I decided to exclude my own experiences from the research. Indeed, the purpose of the

research was to learn how this phenomenon is experienced by other clinicians' experience, so as to obtain a less self-involved perspective on it. To have included my own experiences would have only diluted this focus.

> A phenomenological study is
> one that focuses on descriptions of people's
> experiences and how it is that they experience
> what they experience. (Patton, 1990, p.71)

This model corresponds exactly to the goal of the study. With its focus on internal experience, it is ideally suited to the process of exploration and discovery of complex and largely private internal states. Unlike a heuristic approach, a phenomenological approach can be used to study the internal experience of the subjects without reference to the researcher's own internal experience. Furthermore, it is specifically designed to explore experiences which are intrinsically fused with the individual's subjective interpretation, as is the therapist's identification with the patient (Patton, 1990, pp.69-71).

METHODOLOGY

The Pilot Study

This study was an expansion of a pilot study that was conducted on the same phenomenon. This pilot study was undertaken as part of the requirements for a doctoral level course in qualitative research methodology.

The pilot study utilized a phenomenological qualitative interview approach. This approach was selected for the reasons described in the previous chapter. It contained a sample of eight subjects. An interview guide, which provided a overall structure for the interviews while allowing for open ended questioning, was used in the interview process. Each interview lasted 45 minutes to an hour. The data was analyzed utilizing a deductive mode of analysis in which themes from the material were identified and sorted into categories, sub-categories, and sub-sub categories. (As it was intended as a pilot study, only one category of material that emerged in the data was analyzed.) A minimum of two examples of each theme were required in order for a particular piece of data to be identified as a theme, and used as a sub-category or sub-sub category. In the written analysis, each sub-category or sub-sub category was illustrated with at least two examples of data.

The results of the pilot project demonstrated that in-depth qualitative phenomenological interviewing of the type that was selected was capable of capturing the complexity and

the subtlety of the therapist's identification with the patient. For this reason, the methodology for the present study was essentially the same as that used for the pilot study.

However, the results of the pilot study also revealed certain limitations in the initial research design. These limitations were adressed in the design of the present study. Those elements of the methodology utilized in the pilot study which accomplished their goals were retained, while those elements which did not work were be changed. Where changes have been made, the differences will be noted and explained in the relevant section of the text.

Choice of methods

This study was qualitative and phenomenonological in nature. The reasons that these methods were selected, as well as the tradeoffs which accompanied these choices, have been outlined in detail in Chapter 3.

Source of Data

The phenomenon of the therapist's identification with the patient has been explored with two different sources of data -- the perspective of the supervisor, and the perspective of the therapist. The material in the literature on empathy and parallel process is, by and large, written from the perspective of the supervisor, while the literature on countertransference has been written from the perspective of supervisors as well as through self-reports by therapists.

This study utilized the perspective of the therapist as the source of data. This choice involves a number of tradeoffs, which will be outlined below.

An advantage of approaching this phenomenon from the perspective of the supervisor is that the therapist is often not conscious of the phenomenon, and the supervisor may be in a better position to observe it than the therapist himself. The disadvantage of this approach is that reports by supervisors have tended not to describe the internal state of the therapist who is experiencing this phenomenon, except in the most general terms. For example, Arlow (1963) reports a case in which a therapist in supervision is describing a characteristic gesture made by the patient and then, unconsciously and uncharacteristically, makes the same gesture himself. Arlow uses the anecdote as an example of what he calls a transitory identification. Except for this broad label, however, he does not describe the internal state of the therapist in any detail. Thus, his observation is limited to what can be observed, not what the therapist feels.

Clearly, this type of report is limited in terms of its ability to further illuminate the quality of the experience. Furthermore, there have been numerous descriptions of these types of observations in the literature on parallel process, and they are remarkably consistent. Further research of this type would appear to be redundant.

Self-reporting, as is relatively common in the literature on countertransference (eg., Spotnitz, 1979) has the advantage of describing the internal state of the therapist in more detail. The drawback, of course, is that self-reports are obviously limited to what writers are able to self-observe and are willing to report in the literature. There are currently not enough reports extant in the literature to obtain a systematic overview of the phenomenon.

Interviewing therapists themselves, therefore, provided access to the internal experience of the therapist while permitting systematic exploration of the specific questions that have been raised. For example, questions about the intensity of the identification, the relationship of the identification to the therapist's own personal emotional state, and the types of experiences which enable the therapist to gain awareness of the identification ccould all be thoroughly explored through interviewing the therapist about her experiences.

The drawback with this approach is that it was not able to capture observational data of the kind that has been reported by supervisors. As was mentioned above, not all examples of identifications with the patient reach the therapist's awareness, even in retrospect. Clearly, those instances of the process that the therapist was not conscious of were not available.

For this researcher, however, the most compelling questions about the phenomenon are those which concern the therapist's internal experience of the phenomenon. It is information about this aspect of the identifications which will enable therapists to better identify the experience of identification as it arises in the course of their practice. For this reason, the benefits of interviewing therapists about their internal experience of the phenomenon outweighed the benefits of obtaining observational information from supervisors.

The interview process

The use of an interview guide

This study made use of an interview guide as the exploratory instrument. The guide contained a series of questions and related exploratory probes about various aspects of the subject's experience with the phenomenon. However, this instrument was flexible enough to allow the researcher to explore any unexpected material that arose in the course of an interview.

The use of an interview guide in preference to a less structured, conversational style of interview was made to assure that basically the same material will be covered in each interview. At the same time, in contrast to a fixed questionnaire, the use of the interview guide was flexible enough to permit the range of individual differences among subjects to be explored in depth (Patton, 1990, p. 283).

The results of the pilot project indicated that the use of an interview guide is an effective research instrument for this type of inquiry. Although the elusive nature of the material was evident in the data collected, the interviews were able to capture anecdotal material which was both rich in content and illuminating. Indeed, several concrete examples of manifestations of identifications were obtained that have not previously been described in detail in the literature. In the present study, more examples were obtained.

Evolution of the interview guide

When I first began to develop the guide, I was primarily thinking about exploring parallel process in the most narrow and traditional sense of the term -- the instances in which the therapist unknowingly re-enacts his patient's behavior towards him in his relationship with his supervisor.

As I began to develop questions that moved in this direction I began to feel that the focus was actually too narrow. For one thing, I realized that there are numerous descriptions of this particular phenomenon in the literature. While these are interesting, there is almost a monotonous, mechanical quality to them in that they tend to focus on this re-enactment as a sort of ubiquitous but idiosyncratic micro-phenomenon within the supervisory process. There was often little attempt to link these incidents to the broader phenomena of empathy and countertransference. Thus, I

realized that the earliest form of my guide did not really capture the total breadth of the phenomena that I wished to explore.

As I reflected on the idea further, I decided that what I really wanted to explore were all of those incidents in which the therapist's identification with the patient spills over into other areas of his life -- including, but not limited to the supervisory relationship. I wanted to explore the nature and the intensity of this phenomenon, and to find out how the therapist becomes aware of it and manages it at times when no supervisor is present. Furthermore, I wanted therapists' own ideas about the cause of the process -- whether is it primarily due to something in themselves, something in the patient, or some combination of the two.

The evolution of my interests in this area was reflected in the guide that was used in the pilot project. At that time, the guide was divided into three major sections (the guide can be found in the appendix):

1) The experience of adopting a patient mode of functioning in general.

2) the enactment of this phenomenon in the therapist's supervision or personal psychotherapy.

3) The therapist's ideas about how and why the process occurs.

The guide was used with eight subjects in the pilot project. Although only one major category of material was

analyzed in the pilot project -- the phenomenology of the identification -- this guide was found to have one major deficiency; it was still focused rather narrowly on identifications which were extreme or out of control, as opposed to the whole range of possible manifestations. In particular, material about well-controlled identifications -- the transient identifications described primarily in the literature on empathy -- was not captured with the use of this guide.

Furthermore, my reading of the literature on parallel process led me to specifically explore manifestations of identifications with patients which were enacted in supervision or in the therapist's personal therapy. Although anecdotes about these settings were obtained, they did not appear to be either especially frequent, nor particularly different than other types of identifications.

These deficiencies were addressed in the configuration of the guide used in this study. Manifestations of identifications in supervision and the personal psychotherapy of the therapist were still be explored, but with less specific emphasis on these areas. Rather, the present form of the guide focused more consistently on all possible manifestations of identification with the patient.

There was also some change in the language used in the guide. In the pilot study, I refrained from using the term *identification with the patient* in favor of ordinary language

such as *feeling like the patient*. The purpose of this was to focus as specifically as possible on the experience of the phenomenon, and to avoid contaminating the inquiry with jargon.

While well-intentioned, this technique did not prove useful. The ordinary language was not specific enough to communicate to subjects what I was interested in, and it caused them to give overly restricted responses. After it was clear that I was interested in experiences of identifications, however, they were then able to describe a much wider range of experiences. Thus, this term was used from the start in the current guide.

The Interview Guide

The following is the guide that was initially be used in the interview process. It is based both on the experience and the results of the pilot project, and on a more profound immersion in the literature than had been undertaken at the time of the pilot project. This guide worked well in the interviews, and was not changed in any significant way in the course of the study.

Interview Guide

1) Do you find that you identify with patients in the course of doing psychotherapy? Do you identify with their feelings? With their thoughts? With their behavior?

2) Give an example of an experience of identifying with a patient in which you felt that you were completely under control. What was the setting (i.e. in the session, in supervision, or in your outside life?) What did it feel like? At what level were you identifying -- emotionally, cognitively, and/or behaviorally? Were you consciously aware of it at the time? If not, how and when did you realize that it was occurring?

3) Do you have an example of an experience of identification in which you were out of control?. What was the setting? What did it feel like? At what level were you identifying -- emotionally, cognitively, or behaviorally? Were you consciously aware that it was occurring? If so, did this awareness help you to control it? If you were not conscious of it at the moment, how did you become conscious of it?

4) Can you identify factors which seem to lead to an identification getting out of control? Professional factors: Phase of treatment? Diagnosis? Borderline disorder? Post-Traumatic Stress Disorder? Incest Survivors?) Personal Factors: Real commonalities with the patient? Amount of professional experience? Amount of professional support (i.e. peer groups, supervision, organizational affiliation)? Amount or type of stress in personal life?

5) Can you identify factors which led to an identification being brought under control: Supervision? (What types of supervisory interventions are most helpful) Personal therapy? Theoretical awareness? Self-reflection?

6) What effect do you think identifications -- both in-control and out-of-control -- have on the treatment? On the supervision? On your outside life? Positive effects? (Increased empathy? Patient becomes more aware of your involvement in the treatment?) Negative effects? (Loss of neutrality? Inability to understand patient? Decreased empathy? Ineffective, destructive, or counterproductive interventions?) How do you follow-up with a patient when an identification is out of control?

Duration and setting of interviews

The study used interviews lasting between 45 minutes and one hour in length, with follow-up time with certain subjects scheduled when further elaboration on specific points was required. Interviews of this length were found to be sufficient to capture the material.

The rationale for this was in large part practical. Psychotherapists' time is divided rather evenly into 45 minute to one hour sessions, and it is difficult to schedule interviews lasting longer than that.

Although this is a relatively brief interview time -- shorter than is recommended for this type of research

(McCraken, 1988) -- the results of the pilot study demonstrated that this is feasible. In large part, this is probably because psychotherapists who met the sampling criteria (see below) that have been developed for this study are trained to be both highly introspective and articulate. As much of the training in psychoanalytic psychotherapy takes place within the context of 45 minute to one hour sessions, psychotherapists have learned to reflect on their feelings and describe them within this time-frame. And while the literature on the very specific phenomenon of the identification with the patient is not voluminous, the notion of the transient identification is well-known, and questions about empathy and countertransference in general form an important part of the training. Thus, the idea of the therapist's identification with the patient is not particularly foreign to psychotherapists, and one that they can rather easily discuss. Furthermore, each subject received a copy of the interview guide a least a week prior to the interview. This permitted them to sift through their memories and collect some anecdotes that seemed to be relevant.

Interviews for this study were conducted both face to face, and by phone. Fifteen of the interviews were conducted by phone, and five were conducted face to face. No difference was found between the phone interviews and the in-person interviews, either as regards the degree of rapport achieved with the subject or the quality of data that was obtained.

Thus, phone interviewing was found to be an acceptable alternative to face-to-face interviews.

Sampling

Sample Size

Twenty therapists were interviewed in the course of this study. The rationale for this sample size is outlined below.

According to Patton (1990, p. 184), sample size in qualitative research of this type is an ambiguous issue, and there are no clear rules determining sample size; the specific sample size that is set should be based on the goals of the study.

In this study, the goals were two-fold. The primary goal was to obtain in-depth information about this phenomenon as it is experienced by the therapist herself. It was hoped that the study would capture the generally private, internal aspects of the phenomenon, since it is this type of information that could be most useful in helping therapists to more effectively identify the phenomenon as it occurs in their own practices.

The second goal of the study was to obtain a larger sample than has thus far been described in the literature. The largest samples in the literature are those of Mattinson (1975), with six case examples, and Kahn (1970), with five cases. Furthermore, these samples are drawn exclusively from the supervisory setting. As Patton (1990, p. 185) suggests,

having an extremely small sample size does not preclude the possibility of doing extremely valuable work. However, it seemed important, in light of the present state of knowledge, to explore a larger sample than had been previously described in the literature, both in terms of the number of therapists to be studied, and the range of settings to be explored.

On the other hand, Lincoln and Guba (1985), suggest that the population under study should be sampled until a point of redundancy has been reached in the inquiry. Thus, sampling should cease when no new data is being obtained in the interviews.

It is unlikely that, in a field as complex as psychodynamic psychotherapy, a point would be reached at which no new unique anecdotal data was being obtained, but it seemed possible that the specific trends that new anecdotes represented could become redundant. Even in the pilot study, which described a sample of only eight (8) subjects, most of the data fell rather clearly into trends which could be identified. It appeared likely that in a somewhat larger sample the point of redundancy would be reached.

For these reasons, a sample size of approximately twenty (20) subjects was selected. This size was small enough to allow for in-depth interviewing to be used, while it was large enough to illustrate a wider range of therapists' experiences than has previously been presented in the literature.

Sampling criteria and rationale

This study made use of criteria-based sampling strategy (Patton, 1990, p.176), in the sense that pre-determined criteria were used in selecting subjects for inclusion. The criteria for subject inclusion were as follows:

1) All subjects will hold degrees in either social work, psychology, or psychiatry, or certification in some type of psychodynamic psychotherapy from a non-degree granting institution.

2) All subjects will have engaged in the practice of psychoanalytically oriented psychotherapy for a minimum of one year, post-degree or post-certification.

3) All subjects will have had at least one year of post-degree supervision that was conducted within a psychodynamic or psychoanalytic orientation.

4) All subjects will have had at least three years of personal psychoanalytic/psychodynamic psychotherapy.

These criteria restricted the pool of samples to a rather specific segment of the population of psychotherapists. (Furthermore, the universe of subjects was further limited to therapists who are friends or acquaintances of the researcher, for reasons of access. See pp. 108-111). However, these restrictions seemed necessary for the purposes of an exploratory study due to the nature of the subject matter to be explored.

As was mentioned earlier, the vast majority of literature on this subject has been produced by supervisors who observed parallel process phenomena in psychotherapists that they were supervising. In almost all cases, the therapist was unaware of his behavior, and required the supervisor's intervention in order to recognize it. In this study, however, it is the therapists themselves who will be interviewed. While they may describe examples of the process which were first pointed out to them by their supervisors, there may also be examples that therapists discovered on their own. In either event, it would appear that this is a difficult phenomenon to perceive, and that a psychotherapist would require a relatively high degree of theoretical understanding and self-awareness to be able to recognize and describe it. All of the criteria for sample selection were formulated with this need in mind.

The specific trade-offs that are associated with each of the criteria will considered in turn:

A) *Possession of a degree and/or certificate, and minimum of one year of psychotherapy practice.* These restrictions are designed to assure that subjects have the basic theoretical knowledge required to understand the connection (or lack of connection) between their own feelings and behavior and those of their patients. Requiring them to have had at least one year of post-graduate practice is intended to assure that they have a sufficient pool of

experience to draw upon to have the potential to serve as an information-rich resource.

These restrictions had the drawback of eliminating the least experienced therapists from the study, the group which some have argued (Eckstein and Wallerstein, 1956; Sachs and Shapiro, 1976; Nadler, 1979) are most likely to exhibit parallel process phenomena. Others, however, have suggested that parallel process occurs at all levels of experience (Searles, 1955; Gediman and Wolkenfeld, 1980). However, it must be kept in mind that this study was focused on the therapists themselves, and thus did not have the advantage of having an observer monitoring the phenomenon that is in evidence in the reports on parallel process that have been written from the supervisor's perspective. Thus, higher degrees of both self-awareness and awareness of the therapeutic process were required in order to have access to the phenomenon than is usually demonstrated by psychotherapists in the earliest levels of their training. Therefore, the decision was made to limit the study to more experienced practitioners, in the expectation that whatever may lost in frequency of the phenomenon (if there is any loss) will be made up for by the increased ability of subjects to understand and reflect upon their experiences with it.

B) *One year of psychodynamic oriented supervision.* Again, most cases that have been reported in the literature have been from the perspective of the supervisor. This suggests that it may not be possible to recognize this phenomenon -- at least the first time that it occurs -- without the assistance of a supervisor, and thus a certain amount of experience in supervision would be necessary to be able to describe it. It is important that the focus of the supervision be psychodynamic because the vast majority of the literature on this topic has been written within the conceptual framework of psychodynamic/psychoanalytic psychotherapy. Within this paradigm, therefore, parallel process is a known phenomenon, and one which it is likely that the supervisor will be aware of. While it may be addressed in supervisory relationships conducted within other psychotherapeutic orientations, it less certain that it would be either noticed or remarked upon.

The major drawback to this restriction is that the experiences of psychotherapists who have not had psychodynamic/psychoanalytic supervision were not included in this study; their experiences may be equally valuable in understanding the phenomenon. Furthermore, including them in such a study might clarify whether or not the phenomenon *does* occur in treatment conducted by non-psychodynamically trained psychotherapists, or whether it is in some sense a by-product of psychodynamic treatment.

C) Three years of psychodynamically oriented personal psychotherapy. Again, the rationale for this restriction is that experience in personal psychotherapy is needed specifically to develop the degree of self-awareness necessary to enable a psychotherapist to recognize and describe the phenomenon. Personal therapy for psychotherapists was first recommended specifically for the purpose of enabling psychotherapists to distinguish their own personal unconscious feelings from those of their patients (Freud, 1912). While the requirement of three years is quite restrictive, it would seemed better to select subjects who would be *most* likely to be able to answer the questions being explored.

It is hoped that the results of this study will provide a clearer description of the phenomenon of how psychotherapists identify with their patients than is currently available.

Subject selection

Potential subjects (i.e., therapists who meet the aforementioned criteria) were selected based upon their availability to be interviewed, and on their ability to provide information rich vignettes or thoughts about the phenomenon.

Each potential subject was informed briefly about the nature of the material to be discussed. They were not asked to determine immediately whether they wished to participate or whether they could contribute relevant data. For example,

one therapist in the pilot study was unclear about whether she had anything to contribute to the study. After thinking about the topic for a week, she realized that she had had a number of extremely intense experiences with the phenomenon, and agreed to be interviewed.

Subject population

Subjects were selected from the pool of the researcher's colleagues and acquaintances. A significant number were drawn from the faculties and student bodies of four psychoanalytic training institutes that the researcher is affiliated with: *Psychoanalytic Psychotherapy Study Center, Mid-Manhattan Institute for Psychoanalysis and Group Therapy, Center for Modern Psychoanalytic Studies, and the Colorado Center for Modern Psychoanalysis*. Subujects not affiliated with these institutions included social workers, psychologists, and psychiatrists who the researcher was either acquainted with, or who are acquaintances of the researcher's acquaintances.

The decision to include colleagues of the researcher in the study raise some concern about objectivity in the study, in that it is possible that subjects who were unknown to the researcher would be less likely to be influenced by what they assume the researcher would like to hear.

This was an important consideration. However, it should be noted that subjects in the pilot study included both colleagues of the researcher as well as people who were only marginally known to him, and no difference was found in the

nature of the responses. Indeed, the researcher was usually quite surprised by how different subjects' responses were from his expectations. Even those with whom the researcher had occasionally discussed case material had very different ideas and experiences than were anticipated. Indeed, issues of character style or theoretical orientation (at least insofar as they were known and understood by the researcher) did not appear to have influence on the type of experiences that the subjects related.

However, it should be understood that while all of the subjects were peers of the researcher, the issues explored in the study were not discussed with the subjects prior to the study itself. It is likely that the issue of objectivity would be more complex if the subjects were either students or supervisees of the researcher, as their thinking on clinical experiences has been significantly influenced by the researcher. Similarly, the issue of objectivity would also have been more complex with the

researcher's own teachers and supervisors. For this reason, these groups were excluded from the pool of subjects, as was anyone with whom the researcher has specifically discussed the issues involved in the study.

In researching this type of material, including colleagues of the researcher was thought to have a number of advantages to the research process. The principal advantage was thought to be that aspects of the material that will be

explored in this study involve experiences that many therapists are hesitant to reveal. Although the idea that a certain degree of transient identification with the patient is an essential element in the therapy is probably shared by all psychodynamic psychotherapists, cases of identification which are viewed as having gone out of control are viewed as countertransference errors. Traditionally, countertransference has been viewed as an expression of the therapist's own personal psychopathology, and the attitude towards it has been rather negative (Tower, 1956). Although some have argued that attitudes towards countertransference have become more accepting (Epstein and Feiner, 1979) -- especially among the objective countertransference theorists -- countertransference that is considered to be subjective continues to be a topic that most therapists are rather reticent about. When it is discussed, it tends to be discussed privately, and with some reluctance.

In view of this consideration, it was thought that the fact that the researcher was known to, and, to some extent trusted by the subject would help the subjects to be more comfortable revealing information about a phenomenon that they might have otherwise been reluctant to discuss.

Of course, it could also be argued that having the subjects be known to the researcher could make them feel *less* comfortable, rather than more comfortable, because it would make the interviewing process less anonymous.

This did not appear to be the case in the pilot project. The subjects in that study, most of whom had close relationships with the researcher, revealed a wide range of experiences, many of them openly describing experiences that they viewed as either being errors, or in other ways out-of-control. Many of them, however, expressed the concern that the experiences might be judged negatively by other professionals, and a number of them specified that material be presented in such a way that it could not be identified. Nevertheless, all of the subjects did feel free to reveal this type of information about themselves, and they seemed to feel safe enough with the researcher to do so comfortably. This was a considerable advantage in obtaining the data.

The situation was more complex in the present study, and will be discussed below in the section on The Interview Process.

The Sample Population

A total of twenty (20) subjects were interviewed, all of whom met the sampling criteria outlined above.

Eleven (11) subjects were female; nine (9) subjects were male.

The breakdown in terms of training was as follows:

Nine (9) social workers, all of whom had either completed psychoanalytic training, or had at least five (5) years of psychoanalytic training.

Eight (8) psychologists, of whom six (6) also had psychoanalytic training.

Two (2) psychiatrists, both of whom had extensive psychoanalytically oriented supervision.

One (1) psychoanalyst, who also had a license in marriage and family therapy.

The subjects had between four (4) and forty (40) years of experience in the practice of psychoanalytic psychotherapy.

The subjects had between four (4) and (25) years of supervision, including peer supervision.

All subjects had a least three (3) years of psychoanalytic psychotherapy. I did not enquire further about the length of time that they had been in therapy, as this appeared to be too intrusive. However, the minimum was approximately eight (8) years, and the maximum was about thirty five years (35).

As was specified in the sampling criteria, all subjects practiced psychodynamic psychotherapy. Within this broad context, however, therapists described themselves as ascribing to a number of different orientations:

1 Classical/Freudian

3 Self Psychology

4 Object Relations

3 Interpersonal

5 Modern Psychoanalytic

1 Freudian/Object Relational

3 Eclectic Psychodynamic.

Data Recording

Verbatim process notes were taken during all interviews. Initially, it was planned that the interviews would also be audio-taped (as they had been in the pilot study), for the purpose of providing a back-up source of data. However, an unanticipated level of defensiveness on the part of the subjects also necessitated a change in this plan. (The reasons for this level of defensiveness are discussed in the following section, The Interview Process.) Although all subjects had agreed to have the interviews audio taped, a number of the first subjects to be interviewed were distressed at the idea. I decided to eliminate the audio-recording with them, and to rely on notes instead. After several interviews, I simply dispensed with the idea of audio-taping alotgether. All subjects seem to be relieved at the change.

The Interview Process

The interview process was rather different than it had been during the pilot project. In the pilot project, the interviews went quite smoothly, and I had little difficulty in obtaining the type of information that I was looking for. The subjects were quite open to sharing their experiences, and spoke candidly about the issues that I was exploring.

In contrast, the process was more complex during the dissertation research. In large part I think that this is due to the fact that I had much closer personal and professional relationships with the subjects in the pilot project than with those in the present study.

The main difficulties I encountered were the subjects' desire to maintain their privacy, their feelings of embarrassment about the nature of the material that I was asking about, and concerns that that their answers would reflect badly on the quality of their practice. A number of subjects and potential subjects had very strong reactions to the project. For example, two potential subjects refused to participate for the following reasons:

> *I'd be happy to be interviewed about any topic except that one. That's just too personal.*
>
> *I'm sorry, but I've really thought a lot about this, and I can't see that there would be any way for me to be honest about answering the questions that would not be extremely embarrassing for me.*

One subject who did participate told me that she would not have done so if she did not have a close relationship with my wife. Still another told me that she had been extremely anxious prior to the interview.

A number of subjects commented on the sensitivity of the topics that I mentioned. One asked me, "People actually tell you about these things?", while another told me that his answers were pre-prepared, and structured specifically to protect his privacy. Other subjects seemed to withhold details of the experience.

I tried to make people as comfortable as possible during the interviews, and at no point did I press subjects to reveal more than they wanted to. However, the fact that a number of subjects did appear to be defensive and guarded has implications for the data that was collected in this study, for the nature of this type of investigation in general, and for the way in which these types of experiences are viewed by psychotherapists. These issues are adressed below, in Chapter 5, **Limitations and flaws in the research.**

Data Analysis

After the interviews were completed, the complete data set was reviewed and submitted to an inductive content analysis. This is to say that

> the patterns, themes, and categories of analysis come from the data; the categories emerge from out of the data rather than being

imposed on them prior to data collection and analysis. (Patton, 1990, p.390)

Anecdotes representative of these patterns, themes, and categories were selected, and further sorted into sub-categories and sub-sub-categories, representing both majority and minority trends and themes found in the material. The questions in the interview guide provided the basis for most of the catagories that were used in the analysis. However, unanticipated catagories also grew out of material that was collected, and was integrated into the analysis, as is typical in this type of analysis (McCraken, 1988; Patton, 1990).

The analysis is presented in the form of illustrative anecdotes interwoven with the analytic interpretation of the data. All anecdotes are drawn from the verbatim interview data.

All interviews are numerically coded for identification purposes, and each anecdote used in the written analysis is labeled with the appropriate code. A minimum of two examples from two different subjects is used to illustrate each category, sub-category, and sub-sub category used in the written analysis.

Ethical Issues

All subjects were informed that the interviews were being carried out for research purposes. They were assured that their participation was voluntary. Furthermore, each subject had the right to request that all or part of the material

that they revealed in their interview could be omitted from the written analysis. Each subject received and signed a *Statement of Informed Consent* prior to participating in the interview process.

In addition, each subject was informed that all data would be disguised sufficiently to protect the confidentiality of both the therapists and the patients. All identifying data, either of the patient or the therapist, was disguised.

ANALYSIS OF THE DATA

Centrality of identification to the therapeutic process

All therapists reported that they identify with the patient in the course of practicing psychotherapy, and many reported that they do so regularly.

> *I think that I identify all the time, in every session. (#2)*

> *I identify ubiquitously. (#14)*

> *We are like pianos, constantly resonating to different frequencies all the time. (#12)*

> *It has recently struck me that one of things that makes this hard work is that you are always working from your own issues, either with your issues, or against your issues, or through your issues. And all of this involves identification.(#20)*

For a number of therapists, the experience of identification is one of the most fundamental components of the work. While the reasons offered for this idea were not uniform, there was a general agreement that the identification with the patient was a critical element in developing the type of emotional relationship with the patient that the practice of psychoanalytic psychotherapy requires.

> *I see the treatment as the unfolding of these kinds of projective identifications. Without it all becomes abstract, as though you have sucked the life out of it, pulled out the plug. (#3)*

> *It is very important that I find something that I like in a patient and feel sympathetic with. Finding a way to experience the patient as being more like me than not is absolutely crucial. (#17)*

> *I think that identifications are essential to treatment. Once you become sensitive to it, you begin to realize that you experience a continuous series of identifications which you analyze as a source of information about the patient. (#19)*

The process of empathy involves identification. It's about finding commonalities of emotional experience. Not a blanket identification, but that the part of me that relates to what the patient is experiencing becomes paramount in my consciousness. (#13)

Identification is part of the big picture, part of the question of how does one human being relate to another. Part of becoming a psychotherapist was being made conscious that I would identify with the patient, that I would try to understand him using my own feelings, and that I would acknowledge how I felt. It also involved knowing that I would go into analysis to understand this, that I couldn't simply practice without having a very good idea of what it was like to be a patient. I often thought of some quote of Freud's, to the effect that nothing human is alien to me. There was always a lot of emphasis on the fact that being a doctor does not make you different from the patient except in that, presumably, you have some advantages -- your training, your own therapy -- that help you to see them from a different vantage point than they can see themselves. It is the commonality with the patient that has a special emphasis in psychotherapy. (#15)

Identification is very rooted in the very nature of the work. You are working with people with whom you may have very little in common, and with whom you might have nothing to do with in your outside life. You might not share their values, or you might even find them repulsive. So what is the motivation to treat them, besides making money, and exercising your craft? It's the ability to identify with something in that person -- their personal struggle, or their wish to make contact with me. It enables me to make contact with them, with somebody I might not otherwise have been in contact with.(#14)

ASPECTS OF THE PATIENT'S FUNCTIONING THAT THERAPISTS IDENTIFY WITH

While all therapists agreed that they identify in the course of doing psychotherapy, therapists identified in different ways with different parts of the patient's personality. Identifications with the patient's feelings involve sharing the same or similar feelings with the patient. Cognitive identifications involved having the same thoughts

as the patient, or engaging in the same type of thought process. Behavior identifications involved actually behaving like the patient, whether in the session or outside it in another setting.

Many therapists said that they identified most often with feelings, less often with thoughts or thinking, and least often with behavior.

> *I identify mostly with feelings, then thoughts, and only occasionally with behavior. I identify most in sessions. When I am identifying on an affective level, I feel very closely related to the patient, and closely related to myself. It is most intense on an emotional level. When I identify cognitively, it is never at the same level of experience. (#1)*

> *I identify . . . mostly with feelings, less with thoughts, and a little with behavior. (#5)*

> *I think that I identify with patients almost every session. It's usually with feelings, with an experience. However, I can identify with obsessive thinking, and less often with their behavior (#2)*

> *Yes, I identify with all three. Mostly with feelings and thoughts. Also with behavior, although that is much less common. (#18)*

However, some therapists reported that they tend to identify regularly in all three ways.

> *I identify with patients on all levels. Definitely, in equal measure, feelings, thoughts, and behavior. (#17)*

> *And I am aware -- or at least I try to be -- of how my feeling tone is affected by a patient. And also how my cognitive style is affected by a patient's emotional style. With a patient who is obsessive I can easily be dragged into their obsessions. If a patient is impulsive I can feel impulsive -- I find myself biting my tongue to not say what I feel impelled to say. If a patient is hopeless, it is very, very easy to feel hopeless. . . If a patient is rejecting, it is very difficult -- and sometime impossible -- not to act rejecting. (#13)*

I identify on all levels. I find that I generally meet the patient at the emotional level that they are at. If they get all riled up, so do I, at least inside. If they are getting angry, I can feel myself getting angry too. They tell me I always look calm, but on the inside I am not. (#4)

I identify on all levels. Especially in the hospital, where the patients act out more, I do too. (#12)

TYPES OF IDENTIFICATION

SIMPLE IDENTIFICATIONS

The most frequent type of identification that was reported by therapists will be called a simple identification.

In a simple identification, the therapist has the same type of feeling, thought process, or behavior as the patient, and the similarity between the therapist's feelings and the patient's feelings is straightforward.

Therapists described examples of simple identifications that were both in-control and out-of-control.

In-control simple identifications

In most cases of in-control simple identifications, the therapist has the feeling of understanding the patient on a rather deep and intimate level, in an emotional way that is not restricted to simple intellectual understanding. There is usually a feeling of kinship with the patient. The therapist identifies with the patient (or, in couple work,with one of the patients), and comes to feel that she and the patient are extremely similar -- or even identical -- in some important way. They may have shared similar experiences, they may think alike, or they may have the same reactions to

specific events. These types of identifications correspond rather closely to empathy, as it is described in the literature (Greenson, 1960; Arlow, 1963; Beres and Arlow, 1974).

In many examples of in-control identifications, the identification is based on some sort of similarity between the patient's life experience and the therapist's life experience. Usually, these experiences are somewhat circumscribed in that the therapist identifies with some particular life experience of the patient. Although the feelings of identification might persist for a long time, the therapist is able to establish a more or less comfortable amount of distance from the patient, and her functioning is not impaired by the identification.

The basis of the identification varies. Identifications are often based on similarities between the patient's and the therapist's childhood experiences.

> *There was one patient whose mother was paralyzed on one half of her body. Whenever her mother would call her she would come running, because she wanted as much attention and love as she could get. So her mother would call her, and as soon as she got there her mother would kick her with her good leg. I could really identify with the feelings of terror, of horror, of betrayal that she described. I felt they were my own. I felt victimized like that a lot. (#10)*

> *I was thinking about a recent patient, in the mental health field. Since she started her training she has been unable to tell me anything about her work, about her classes, or about her patients. It was becoming a real problem, because it was an important part of her life and she couldn't say anything. Then she started telling me about memories of her mother. How she had to hide everything from her. She started playing the cello, and her mother couldn't stand her practicing. She had to go into the basement, and eventually she had to give it up.*

There, I felt completely identified with her, with having to hide to things from my parents, with having to keep my own feelings secret. As I have become identified with her, she seems to be breaking through the barrier, and is telling me more about her life. I don't know whether this helped really, or whether it was just a coincidence. It felt like it helped, and it certainly didn't hurt. (#2)

I have a patient who has an alcoholic father. I come from a family with two alcoholic parents, and I identify with his feelings, his thoughts, and his behavior. I identify with how he behaved when he was little.. I feel very empathic.(#12)

I have one patient who has a schizophrenic mother. He is always trying to cure her, to find a therapist for her. I saw her too. He wanted me to fix her for him. Then, he told me that he was referring her to me because he was tired of carrying the whole burden of her. Now that, I could identify with. I was tired of carrying the burden of my mother, of her depression. My mother even once said to me that she wished that I had a twin so that I could share it with somebody. I always tried to find therapists for my mother too. (#10)

I have a patient right now who is in the field, and she is working on her dissertation, and she feels like she just can't do it. I identify with that a lot. Like she came in one day saying that she couldn't go on with it, she couldn't complete it, and I knew exactly how she felt. It brought back all kinds of memories, this idea that you just can't do it. The patient comes from a very low socio-economic position, just like I do. Poor working class. And she really doesn't want people to know her background, as if it was some sort of character flaw. Now, she is very successful. She works in business, she goes to extremely expensive restaurants and hangs out with really wealthy people. But still, there is a lot of shame. She doesn't want to allow people to see where she came from, what her mother looks like, like all of that is not part of how they know her. I identify really deeply with this. I know that no matter how successful you are it takes a very long time to let go of this very deep shame, this sense that having been poor was something that was your fault, something you did. (#16)

In other cases, more current adult life situations formed the basis of the identification.

Recently it occurred with a patient whose father died. It re-connected me with when my father died, it brought up all of those feelings and I felt very close to her. However, her

behavior, how she actually dealt with it, was very different, and that helped me to maintain some distance.(#1)

One woman often talks about the loss of her mother. She lost her very young. It is a big part of the treatment. It's always on-going with her. I'm always identified with her, because I lost my mother as an adult. I just sit with it and feel it. I think that it helps her in that I really know what she's talking about. It's usually conscious. (#4)

A man came to see me and he had recently broken up with a woman with whom he had been seriously involved. He was doing pretty well with it. He wasn't suffering too much. He wasn't terribly depressed, or consumed with feelings of loss. Then, about two months later he saw her in a car, with another man. He began to experience intense fear, and intense longing to see her. I could totally understand his feelings, as I had had a similar experience about six months earlier. In some ways it was totally irrational, even if one could intellectually understand the experience. But I understood it perfectly from an emotional point of view.(#6)

There was one patient who was really trying to extricate herself from these destructive relationships that she was was repeatedly into. I admired her ability to stick with it and be sucessful, when I identified with her pattern but I was not as sucessful at getting out of it as she was. Sometimes when I asked her a question, I would get an answer that I hadn't expected, because she was doing so well. However, I was able to pull myself together enough to handle it in a way that was helpful for her, even though she was handling a situation differently than I was. (#9)

I had been seeing a patient who had come back after having been out of treatment for a number of years. She had learned that she had cervical cancer. Now, I had been diagnosed with leukemia about 15 years ago. Now, everything that she was going through, her fears, her worry, her struggles, I identified with all of it. It was feeling like we were going to go through exactly the same thing. I wanted to take care of her, to tell her what to expect, to tell her what would happen. What it would be like when she went down to that horrible radiation room, where they would give her a smock and put purple dye on her so that they would know where to radiate her. What it would be like to have that horrible feeling of depersonalization that would have you clawing at holding on to your identity. Despite the time I had worked with her, I had decided that I wouldn't interject my own experience unless she contacted me about it in some way. I was completely identified with her, completely over-identified with her, but I was completely in control. (#8)

Other times identifications were based less on particular types of life experience, and more on general feelings of similarity with the patient.

> *I have a patient who tends to get really anxious. He anticipates disasters and catastrophes in the extreme. Then, to cope with his anxiety, he attacks himself and he attacks me. Thus, there are many reactive attempts to deal with his anxiety. I can really tune into his disaster mentality. Right now I am trying to rent my office and it feels like the same kind of thing. . . I am very comfortable with this level of identification. I can keep a helpful distance and then intervene in many different ways which are very helpful to him. I can identify with his extremes of behavior without getting over identified. (#14)*

> *There is one patient, I always just feel like I am with him. I know what he is talking about, and I can identify with his feelings. I'm very much in tune with him. On top of it. He often feels controlled, intruded upon in his privacy. It brings up a lot of similar memories with me, like I've been through the same things. (#18)*

> *Recently, in the last year, I have been writing . . . This was a big change for me, and I hit a higher level of anxiety than I think I ever felt. I think I had my first true panic attack. . . At the same time, there were two people in my practice who were having trouble writing. They were students, working on papers and dissertations. I wondered how I could help them, if I couldn't help myself. . . . I was so uncomfortable in the sessions, I thought I was going off the wall. I was feeling like 'How am I going to get through the session? Maybe I just won't. Maybe I'll just end it.' But I just sat quietly, and got through it, and so did she. (#20)*

> *I have one patient who is a great patient. He can really benefit from the process. He is a very sad individual. Sometimes it frightens me to be with him because I feel like it will tap into my own sadness in a way that I have never done before. (#12)*

Some therapists, however, reported examples of identifications which were in-control, but which did not appear to relate to, or be based on, their own life experiences in any significant degree. These identifications

might be viewed as examples of objective countertransference, in that they seem to be induced by the patient, and dependent on the patient's dynamics, as opposed to perceived similarities between the patient's dynamics and the therapist's dynamics.

> *I am working with an obsessional male neurotic. I sometimes feel that my thought process mirrors his. He has a tremendous amount of difficulty expressing himself verbally. At times, he describes himself as sort of a machine, feeling that he is trapped inside of this machinelike immobility. I often feel that I think the same way, that I am inarticulate and trapped and can't say anything. I don't feel out of control with it. But the quicker I can identify what is happening, the quicker I can use it in the therapy, rather than me just being like him, and him just being like me, and us being rather stuck in that. But there is a bit of a lag between the time that it occurs and when I recognize it. (#19)*

> *Another time it occurred with a borderline patient with whom I was terminating. She was getting psychotic and paranoid. She constantly had thoughts of one or the other of us being executed. At one point I had the thought of her jumping out the window, and also laughing. I think that I was identifying with two of her feelings -- her suicidality and her sadism. (#19)*

> *I had a single session with a patient on kidney dialysis. He was also on steroids. He was hypomanic, and a stand up comedian. So it helped him a lot. He began to joke around with me, and I began to joke back. Now, usually there is a prohibition against joking with a patient. But his mood was contagious, and I thought that it helped him. Was it out of control? I did know that I was doing it. He was wearing a Chai around his neck, so I said that I saw that he was flying high [a pun on chai, which is pronounced the same way.] (#15)*

By and large, most in-control simple identifications that therapists reported occurred in the session. Sometimes, however, these types of identifications were manifested not with the patient, but with the therapist's supervisor or

personal therapist. These are similar to the examples of parallel process
that have been described in the literature, except that the therapists in these examples were generally aware of the relationship between their feelings about their supervisor and the patient's feelings about them, and the feelings were not acted out.

> *The main parallel process kind of experience that I have had is that the patient doesn't come to session, and then I don't want to go to supervision.(#16)*

> *Sometimes when I have lost a case and I feel like a failure, I feel like telling my analyst that they haven't done a fucking thing for me and leaving myself.*

> *I have a patient who has MPD (multiple personality disorder). One of her alters feels very strongly that she needs to be rescued. It is sort of like that in my supervision. I get special supervision with somebody who specializes in MPD, just on this one patient, because she is so difficult. Almost like I need to be rescued too. (#5)*

Occasionally, therapists experienced identifications which spilled over to their outside lives, and indeed appeared to alter their identity in rather small, but emotionally significant ways. In contrast with almost all of the other examples of identification which were obtained in this study, these identifications involved pleasurable feelings. It is a testament to the power of the emotional relationship that can develop between therapist and patient -- that a therapist's contact with a patient could result in enduring identifications in the therapist.

There is one patient that it is particularly easy to identify with. She always seems to think the same thoughts, to have the same feelings. It feels like we are kindred spirits, and this influences me. She is very much involved with politics, and when there is an issue in the air I always have the feeling that we will think the same about it. I wasn't so interested in the kinds of politics that she has before, but now I am. (#10)

I was looking at Haggar the other day and it reminded me of a patient who I really liked and admired. I respected her highly. She was very intelligent and decent, and that is a good basis of identification, because I like to think of myself that way. She had just moved to Detroit, and it reminded me of when I had first moved there, and all the feelings that I had. One day she was telling me that she liked to read Heggar. I had never read it, although I read other cartoons. So here, I thought that I had a chance to get some outside information about her, and I began to read it. And I found that I enjoyed it. for the same reasons that she did. In this case the change in me was permanent. I still read it.(#15)

I have quite a few musicians in my practice. One of them is a jazz musician. He started bringing me CDs that he played on. I started to listen to them, and then to other things, and then I started going to jazz clubs. It felt related to him. (#4)

In most examples of in-control simple identifications, the therapist was conscious of the identification as it was occurring, and it is tempting to conclude that the fact that they were conscious of the identification was what kept it in control. However, there is reason to question this idea. These types of identifications were by far the most frequent type of identifications described by therapists, and some therapists sometimes had a little difficulty in recalling specific instances because they were so common as to be unremarkable. Most therapists said that it happens far more frequently than they are aware of, and this suggests that

therapists can experience in-control simple identifications that they are not aware of. However, because in-control identifications do not lead to problems in the treatment, there is no need to attempt to bring them to consciousness.

OUT-OF-CONTROL SIMPLE IDENTIFICATIONS

Out-of-control simple identifications are those in which the therapist, while under the influence of the identification, loses control of some aspect of her thoughts, feelings, or behavior, either with the patient, with the supervisor, or in her outside life. The element of detachment, the controlled acceptance of the identification that is characteristic of in-control simple identifications are absent in the out-of-control identifications.

One characteristic of out-of-control simple identifications is that the therapist is almost always unaware of the identification in the moment that it occurs; while under the influence of the identification, she is unable to recognize the extent to which her interventions have been influenced by the identification. The identification may lead the therapist to intervene inappropriately. Or, the therapist may intervene appropriately, but for the wrong reasons. In either case, awarness of the identification usually takes place after the intervention has been made.

At other times, the therapist is aware that a mistake is being made, but is unable to bring it under control until she is aware of exactly how she is identifying.

It should be noted that not all out-f-control simple identifications actually disrupt the treatment. The therapist might make the correct intervention under the influence of the identification, but realize, upon self-reflection, that she had done it for the wrong reasons.

> *In this case I was mildly out of control. I am working with a patient who was recently offered to do some work on a project with her supervisor that really goes beyond the boundaries of her relationship with him. She is really excited and talks about how wonderful it is to do this, but also her fear that somebody will think that there is something going on between them. This parallels my own history quite exactly. I worked in an agency where my supervisor crossed the boundaries with me, and then it turned into an absolute nightmare. It was really horrible, and I had to leave. So, this was the emotional background of my identification with her. I realized that I made some remarks to her that were based on my desire to protect her and to punish the supervisor. For example, I suggested that she ask him to acknowledge that what they are doing goes beyond the boundaries of supervision, and that they discuss what the meaning of that is. That might be the right thing to say, and I might have said it anyway, but I said it without exploring it with the patient. The exploration really should have come first, for this might not have been the appropriate thing to say. I am mildly out of control, moving too quickly out of my sense of identification.(#8)*

> *A patient of mine was involved in a messy divorce. He and his ex-wife were involved in a horrible fight over the children, and they were in and out of court. Having been involved with a messy divorce myself, I over-identified with him. I completely ignored his role in creating the difficulties that he was involved with because I identified myself with him, and his ex-wife with my ex-wife. I wasn't aware of this. This was manifested in part by my lack of awareness of who he was as a person. I did not recognize his paranoia and rage at the ex-wife. Then, he was accused by her of sexually molesting his two sons, which was false. I immediately wrote a letter to the court on his behalf. I think that I would have done the same thing today, under the circumstances, but what clued me in to the fact that something else was at work was that I rushed into it, without exploring it with him nor considering the impact of this action on the treatment. (#6)*

In many cases, however, the therapist actually does the wrong thing, and this can have a disruptive effect on the treatment.

> *I was working with a borderline couple. Now, I have had a lot of experience working with couples. I write papers on couples. I know a lot about it. Well, I was working with this couple, and the man suddenly turned on his wife and attacked his spouse [verbally]. It was like a knife. It was awful. Awful because I identified with the wife. And it reminded me of something that happened in my past. As a result, I mishandled the situation. I became very protective of her. He thought that I was taking her side. And he was right! He was very disappointed. I had to think fast to repair the damage that I had done. . . I knew that I was out of control. I was angry at him, and I could feel my blood rising. It had to with being viciously attacked. Once I was conscious of what I was doing I could pull myself out of it.(#7)*

> *I had a patient who was the daughter of holocaust survivors. Due to a feeling of victimization in my childhood, I have always felt a strong attachment to the holocaust. There are also other reasons. A lot of my family in Europe was killed in the Holocaust. This patient's parents were both in camps. She was haunted by the Holocaust, in her dreams, and in her fantasies. She also had a strong feeling of being victimized by her mother. And indeed, she was victimized by her mother. I went along with this for a long time. Much longer than I needed to. It took a while for me to realize that there was something in this for me, that we were stuck in our mutual misery. It didn't help her much at all. (#7)*

> *Sometimes, when I am working with a woman, she meets a man that she wants to marry and wants to bring him in to me to see what I think of him. You know, she wants me -- expects me -- to be objective. But I can never seem to do it, if the woman really wants him. I get all caught up in the romance of it, and I can't ask the right questions. Its like I'm starstruck. I know that it's an identification because it doesn't happen when I am with a gay or lesbian couple. Then, I can remain detached, and I can ask the right questions.(#10)*

> *I rarely ever get headaches, and usually I never get the type that could be called a migraine, with a pain in the eye. But there was one patient that I used to get them more frequently with when I was in the hour. I think it was showing in effect that we had a bond. She later became a psychotherapist, and she went her own way with it. She went in directions that I*

couldn't follow. But I had also felt that I had gone my own way. But I think part of our bond was that I identified with her need to be herself, to go her own way.(#15)

At times a patient will be complaining about men they are dating, and I will throw out some statement like, "Well they are just men, what do you expect?" This is the kind of thing that just comes out of your mouth before you have any chance to realize what it is that you are saying.(#4)

I saw a person who was in a destructive relationship that I identified strongly with, and my interventions with her were not always the best. I got very active in those areas. If I hadn't identified so strongly, I might have been able to sit with it better. (#9)

Out-of control simple identifications were also manifested outside of the treatment setting more frequently than in-control simple identifications. One area in which they frequently came up was in supervision, both individual and group. This type of identification is what is most commonly referred to in the literature as parallel process, in that the therapist relates, either on a feeling or a behavioral level, towards the supervisor in the same way that the patient relates towards the therapist. Unlike the in-control simple identifications which arose in supervision, the therapist was usually not aware of the identification, and the feelings were acted-out in relationship to the supervisor (or supervisory group.)

I've seen it happen with peers, in a peer group. They don't know it is happening until they present it. When it is pointed out to them. (#1)

I have one patient who has a manic defense. He has a level of anxiety that keeps him from being aware of feelings, and being aware of me. When I presented him once in a supervisory group I went into a manic presentation. I was going at it like a machine gun, one thing after another, intellectualizing

and wanted to communicate an enormous amount of material and data and facts and stuff. The people who were listening in said that they felt deadened, and I was bouncing off the wall. The other members of the group were feeling angry with me. They couldn't figure out why my behavior had changed, why it was like an attack. Once we figured it out it all made sense. (#5)

I was in supervision with one supervisor who was very good. I was playing tapes of a very paranoid patient. When I was putting in the tape I broke her [the supervisor's] tape player. It was a brand new tape player! [The therapist had destroyed something, just as the patient would have.] But she realized what was happening, that I was identifying with the angry part of that patient. She was a child analyst, and she chased me down the stairs afterward, telling me to "Kill the Witch". "The Witch" was the patient's own name for the internalized part of her mother [the destructive part, that the therapist had identified with in breaking the tape recorder] that she had internalized in herself. [In this vignette, the therapist thought that she identified with a destructive part of the patient, which itself had been an identification with a destructive part of the mother] (#19)

I was presenting a case to a group, and I found that I couldn't talk, I became thought disordered. The patient was filled with persecutory anxiety, and was a latent schizophrenic. (#6)

Out-of-control simple identifications spilled over into the therapist's outside life more often than did in-control simple identifications. However, there were significant differences between the ways in which these two types of identifications were manifested. First, none of the out-of-control simple identifications effected a permanent change in the therapist. Second, the identifications usually involved negative, unpleasurable feelings.

If I am with a patient who is really anxious, I walk around with free floating anxiety afterward. Or with guilt, I feel like I am a bad person. (#2)

> *This happened with a very borderline patient. He also had multiple sclerosis, and he was bulimic. After the sessions with him I used to go to the nursing station and binge on potato chips, just like he would. This was not characteristic of me. I don't usually binge, and I don't usually like potato chips. If I eat them, I might eat just a few. But never like this. I would realize afterward that I was behaving just like the patient. It was out of control in the sense that it was affecting my behavior without me realizing it, even thought it didn't affect the treatment. (#19)*

> *Sometimes is hard, like with a depressed patient whose depression is not alleviated by the end of a session. Then I am still left with the feelings. They can stay with you for a long time. It doesn't make for a fun day. And you can get a cumulative effect for the whole day. (#5)*

One particular area in which therapists would carry their identification with their patients into their outside lives was their families. In these cases, the therapists would identify with the patients' complaints about their partners or children, and then find themselves feeling critical of their own partners or children.

> *There have been times when a patient criticizes his mate, and I begin to look for similar things to criticize in my husband. This only happens with patients that I idealize. I think that they have very high standards. (#1)*

> *There is one guy who always stirs me up to be critical of my wife. This guy is very critical. Now, basically, I feel like I have a pretty good marriage. But I can be critical too. Still, it happens mostly with him. . . . He married someone who could help him in his career. Now, he is doing very well, and he is extremely critical towards her. And I get to feeling the same way towards my wife. (#3)*

> *Sometimes it comes out in anger at my son. I have a patient who is very critical of his how his son plays baseball. Later, when I was playing catch with my own son. I found that I was being critical of him, that he wasn't catching the ball correctly, or as well as I thought that he should. (#6)*

CHRONIC IDENTIFICATIONS INVOLVING THE THERAPIST'S WHOLE IDENTITY

In most of the examples of identification that have been given so far, the therapist identifies with a more or less circumscribed aspect of the patient's life, feelings or behavior. This is not to say that simple identifications cannot be of long duration, or that they are necessarily lacking in intensity. In some cases, however, the identification with the patient appears to involve the therapist's whole sense of identity, and it can last throughout the duration of the treatment. These types of identifications went on over an extremely long period of time, containing both in-control and out-of-control elements.

> *I started with this patient when I was a social work student, in a clinic, and I am still seeing him. My supervisor said that I had a transference towards him, but I think it was a countertransference. He was a young guy, about ten years younger than me, and he had many of the same experiences as me. He had an extensive drug history. And me, too. He said, and continues to say, exactly the same kinds of things to me that I said to my analyst. Not just the general sense, but very concrete phrases. He had a narcissistic transference to me, and I always felt very close to him. I identified with him very strongly. He used drugs to escape from depression, he was self medicating, and I identified with that. He also had a obsessive pre-occupation with attractive women. I did too, but he was far more successful than me. I was kind of jealous of his success. But I also got some vicarious pleasure out of it. He was like unbelievably seductive. Women just feel all over him. But I was shy. His involvement with women was like the drugs, a form of self-medication, an escape. . . I was usually conscious of it. He would say something so similar to what I had said that it startled me. It did happen with thoughts too, since he thought the same thoughts that I did. But I didn't identify with his behavior. He acted out what I had just fantasized. (#5)*

I worked with a patient for a very long time, back in the time when I was still in analysis myself. My own analysis was very long. She was 4-5 years older than me, of European background, and I identified with her completely. She was very much like my mother, and I identified her with my mother, and since I was like my mother, I viewed her as being very much like myself.

The most significant aspects of her that I identified with were the narcissistic aspects. I was very aware of them throughout. I don't think they were ever really unconscious. However, that didn't stop me from having countertransference difficulties with her. The difficulties often took the form of intolerance for these narcissistic aspects of her. And I think that my intolerance of her was reinforced by my own analysis. My analyst was quite intolerant of those narcissistic aspects in me. His attitude was that we should just deal with them and get on with it. He didn't really accept those parts of me. And what he did to me, I turned around and did to her. However, she had a lot of spunk in terms of fighting back. She had the sense -- rightly I think -- that she was being treated sadistically, and she wasn't going to stand for it. Then, there was a collorary for it in terms of my own treatment, in that I identified with her strength in terms of fighting back. I began to see how she could resolve some of her own narcissistic difficulties in her own way. I began to fight back towards my analyst, to get him to treat me differently. . . At times I was competitive with her, in that I saw how cooperative I was with my analyst, and comparing that to how cooperative she was with me. . . . I was very aware at various points that my behavior was modeled on my own analysts behavior. I would notice things, point them out, both in terms of what was happening and what the potential effects of these things would be in terms of her dealing with other people, and I thought that I was being empathic. In dealing with her self involvement, I was also aware that she was behaving in ways that were reflective of her own level of self awareness. I thought that I was being helpful in pointing things out. But she did not experience it as being empathic. (#17)

PROJECTIVE IDENTIFICATION

In projective identification (Grinberg,1962; Ogden, 1979), the therapist identifies with as aspect of the patient that the patient may not be experiencing in that moment, either consciously or clearly. Or, the therapist may identify

with one aspect of the patient's personality to the exclusion of others. In a sense, this type of identification is more of a theoretical construct than the simple identifications, in that its recognition depends on the therapist's interpreting her experience as being related to an aspect of the patient's feelings. However, it is a relatively common -- and powerful -- type of experience. When projective identification is in-control, it can provide important information about the patient that may not be accessible to the therapist in any other way.

> *I have felt a patient's feelings. Once I saw a man, and it was supposed to be just an initial assessment. He was a rabbi. Now, I had a lot of feelings about this, because I think I expected a rabbi to be different than the rest of us. He came in, a tall, very good looking man about my age, and said that his main problem was anxiety. It was mostly about anxiety about speaking, particularly public speaking. When he left I became extremely depressed, very sad. I think that I felt his sadness -- a sadness that he couldn't express, and possibly couldn't even become aware of at the time. Later he came into treatment with me, and over time the sadness and the depression were really evident. In fact, the anxiety issues were not all that important. The main issue was the depression. He felt very needy, and I had identified with this part of him in the first session. (#16)*

> *Sometimes he is very critical of me, and I start getting critical of myself. Then, I realize that his criticism of me is really grows out of him being critical of himself. So my identification with him clues me into his experience.(#3)*

> *I had a patient who was over-controlled, obsessional, and completely detached from her feelings. At one point she had been planning to have an operation, and she seemed pretty calm about it. In the session before the operation she alluded to a fear of dying on the operating table. She called it lightly "the death thing' -- and she made some sort of general comment about not seeing me anymore. I couldn't get her to make another appointment. I wanted to ask her if she was afraid of, or planning to die in surgery, to join her dead mother. But I was the one who was scared. I became terrified*

that she would die. I think that I was feeling her fear, which she couldn't feel. (#11)

When this type of identification is out of control, it can be very disruptive to the treatment. This is a difficult type of identification to recognize because the feelings that the therapist is experiencing are not clearly or immediately related to the content of what the patient is talking about. The therapist has to step back from the experience and compare it to the total clinical picture in order to understand what is going on between her and the patient.

I'm treating a patient who is highly manipulative. She also has a thought disorder. She is making it impossible to treat her. She is impossible to structure. With her, even though I understood what was happening, I couldn't stop it. I was feeling very pressured to keep her satisfied. Like I had to please her all the time. Until I figured it out, until I figured out which impulse was acting in me, I couldn't get a handle on it. Once I did, it changed the next session. She feels very controlled. So to defend against it, she was making me feel controlled. And she was giving me the feeling of not wanting to be controlled, which is also her feeling. (#18)

I had a patient who was always presenting himself as a pathetic guy. This came out mainly in his inability to have any sorts of relationships with women. He really viewed himself as a loser par excellence. I think I pitied him, and I was completely identified with his feeling about himself, seeing him as someone who had this miserable life, a loser. I was so absorbed in this that I missed his hostility, and how he denigrated the therapy. He used to refer to therapists as mercenaries who were only in it for the money. Eventually he became openly hostile. But my identification with the part of him that thought badly of him was completely out of control and I couldn't deal with him. (#14)

SYMMETRICAL IDENTIFICATIONS

Another type of complex identification can be called a symmetrical identification. In a simple identification, the therapist and the patient have the same view, feeling, or reaction to the world; in symmetrical identification, the therapist and the patient have the same feeling about each other. The therapist identifies with the way that the patient feels about the therapist, and then feels the same way about the patient. Thus, the patient's feelings and the therapist's feelings about each other are mirror images. As in the previous types of identifications, therapists described examples that were both in-control and out of control. As with projective identifications, these types of identifications seemed relatively difficult for therapists to detect, perhaps because there was no external point of reference which served to highlight the similarity in their feelings. The in-control examples will be given first.

> *One patient came in with a very hostile attitude. He said that he didn't believe in therapy, that he was skeptical of psychologists' abilities to help people. He intended to see somebody for medication, and he was really not inclined to engage in this talking process. After a few sessions he told me that he didn't think that I had anything very smart to say about him, and that I was basically lazy, in that I just sat and listened while he talked. Part of me thought, "What do I need this shit for?" He was hostile, critical, and didn't look like he was going to make it as a patient. Why not just get rid of him?" But it was too early in the treatment to do that. And besides, I realized that this was the same feeling that he had about me! So I decided to do to him what he was doing to me. I said things to him that if I was with somebody else I would attribute to hostility. I interpreted his behavior to him, with a lot of feeling. I explained how he was nasty to me, how he was derisive, and how he was setting*

the situation up to fail. Consciously, this was very dystonic to him, but unconsciously it was very syntonic . . . It calmed him down a lot. I think that it helped him to feel safe, to feel understood. I think he took comfort in the fact that I was identified with him, that I was just like him, that I was every bit as nasty as he was. And I was. I controlled myself, and did all of this in a studied way, but all the while I was fighting the urge to tell him simply to never darken my doorstep again.(#5)

I find that after about a year into treatment something happens with almost all of my patients. They tell me in a variety of ways that they want to get closer to me. A lot of patients develop erotic transference at this point, the men and the women. I notice it because it usually starts when I look at them at some point and I notice that they look really good. I step back and look at what is going on in the treatment and I see that is their feeling, it's an empathic resonance. (#4)

The out-of-control examples of symmetrical identifications appear to be very difficult to manage, and had the potential to create very serious problems in the therapy.

In the hospital, I forget sessions. The patients don't want to come to session, and neither do I. The time for the session comes and I forget. And the patient forgets too. So far, no amount of supervision has been able to help this, even though I get good supervision. The patients are very resistant, and so am I. The experience with the patient may not be unpleasant. There was one patient with whom it was particularly nice. We would meet for session outside, and we established a very rich silence, and sort of deep silent connection which appeared to be neo-natal. I felt that we were just floating together, and at the end of the session she really smiled. But then we forget, both of us. Why would I want to forget something like that? I think that on a very deep level she does not want to relate, and it makes me not want to relate. (#12)

There was a very filthy woman that I treated as an in-patient. She really smelled terrible. She had a group of friends, and they were all depressed. A couple of them had made suicide attempts, and one had completed a suicide. It was really hard to make a connection with her. I felt that she was just buried behind all that filth. I told my supervisor about it, and I told him that I hated her, and asked what I should do about it. He told me that it was OK to hate her. That was

frustrating, because I knew that it was OK to hate her. What I wanted to know was how to use the experience constructively. But he just said, "of course, she is a disgusting patient, who wouldn't hate her." He didn't understand that I wasn't discussing it with him to drive nails through my hands, or to get permission to hate her. I really didn't have the theoretical understanding to understand the experience. Well, one day she tried to slash her wrists on the ward, and I happened to be the doctor on duty. I knew that I was enraged. The nurses told me that she was agitated, and asked if I could give her some medication. I ordered some Ativan to be given by injection. The head nurse looked at the order and then asked me about it. She asked why it should be given by injection when she would take it orally. I became very dizzy and nearly fainted. I realized that I had ordered the prescription in that way out of sheer aggression towards her. I think that this was a mirror image of her aggression towards me, and of her aggression towards herself.(#19)

I had a creepy patient. He was a necrophiliac. He used to have fantasies about flaying people -- and this was before The Silence of the Lambs. And he used to have fantasies about people having heart attacks while he was having sex with them. I felt increasingly uncomfortable with him. Especially after he told me that he was falling in love with me. He was a control freak, as you might imagine. He wanted to control everything about the treatment. He refused to use the couch, and when he came in, he needed to arrange the furniture in a particular way. I began to feel controlled, and out of control at the same time. Once he told me about an erotic dream that he had about me right after he told me about all of the people that he wanted dead. I started to act the way he did. When he started to get obsessive and compulsive about the furniture, I didn't simply allow him to do whatever he needed to make himself feel comfortable. I started to explore it with him -- compulsively. I knew that it was disturbing him, I could see it. I was challenging his defense. I knew that my getting so compulsive in my questioning of him meant that I was humiliating him. I knew that I shouldn't be doing that if I wanted to keep him as a patient. But by humiliating him I was doing to him what he was doing to me. I was sort of half conscious of this. And sure enough, he left. (#13)

SUMMARY -- TYPOLOGY OF IDENTIFICATIONS

Four major types of identifications were found in this study. These are defined in Table 1.

Table 1.
Definitions of identifications

Simple identification: Identification in which the similarity between the therapist's thoughts, feelings, or behavior and the patient's thoughts, feelings, or behavior is clear, straightforward, and obvious.

Chronic identification: An on-going identification in which the therapist consistently views or experiences the patient as thinking, feeling, or behaving in ways which are similar or identical to the therapist's thoughts, feelings, or behavior, and in which the therapist's whole identify appears to be similar or identical to the patient's.

Projective identification: A state in which the therapist experiences a thought, feeling, or behavior which she believes to be a aspect of the patient's personality that the patient is neither aware of nor consciously experiencing.

Symmetrical identification: A state in which the therapist has the same feelings for the patient that the patient has for the therapist.

All types of identifications were found in both in-control and out-of-control manifestations. A complete summary of all of the types, sub-types, and sub-sub-types of identifications can be found below in Table 3.

Table 2.
Typology of identifications

I. Simple identifications
  A. In-control simple identifications
    1. In-control simple identifications occurring in the session with the patient (corresponds to *empathy* or to *transient identifications*)
      a. based on childhood experiences
      b. based on adult experiences
      c. based on a general feeling of similarity with the patient
      d. based on induction of feelings from the patient
    2. In-control simple identifications which occurred outside the sessions with the patient
      a. In individual or group supervision
      b. Enduring pleasurable identifications with specific areas of the patient's interests
  B. Out-of-control simple identifications
    1. Out-of-control simple identifications in the session with the patient (corresponds to *overidentification*)
      a. Identifications in which the therapist intervened appropriately, but did as a result of the identification, rather than out of sound clinical thinking
      b. Identifications which led the therapist to intervene inappropriately.
    2. Out-of-control simple identifications occurring outside the session
      a. In supervision or the therapists personal psychotherapy (parallel process that the therapist is unaware of)
      b. In the therapist's personal life
        (1) The therapist feels like the patient when she is alone
        (2) The therapist feels towards her family members the way the patient feels towards her family members.
II. Chronic Identifications involving the therapist's whole identity
III. Projective Identifications
  A. In-control
  B. Out-of-control
IV. Symmetrical Identifications
  A. In-control
  B. Out-of-control

THE EFFECT OF IDENTIFICATIONS ON THE TREATMENT

Positive effects

All therapists agreed that identifications could have extremely positive effects on the treatment. Identifications which are in good control serve as a supportive backdrop against which the rest of the treatment unfolds. The benefits, in terms of understanding the patient and being able to communicate this understanding, pervade the therapy.

> *You really understand the patient, and the patient picks this up. Not just patients in a state of narcissistic transference, but all patients need this, and they form a better attachment to you. You understand the patient's unconscious better as well, if you understand your own. (#6)*

> *It helps to have an empathic awareness of what the patient is going through. It also helps to explain the intensity. It also serves the patient in that you are a container for their toxic feelings. And if you can stick with the feelings without acting on them, it serves as a model. If I know the feeling well enough, I can feed it back to them in a way they can use it. (#5)*

> *In-control identifications help because you can really understand the person in a more profound way. (#8)*

> *You couldn't do therapy without it. It is essential if you are to be really with the patient.(#18)*

> *Identification helps you to be more patient, because you understand how long it takes to change something in yourself. You really understand the patient, and the patient picks this up. Not just patients in a state of narcissistic transference, but all patients need this, and they form a better attachment to you. You understand the patient's unconscious better as well, if you understand your own. (#6)*

Besides the general positive effects that identifications could have on the treatment, therapists often described examples of identifications which were helpful in a very

specific way. At times it enabled them to articulate their understanding of a patient's problem in a particularly helpful way, or it enabled them to understand as aspect of the patient that was not immediately obvious.

> *I have a patient who is having a baby. She is terrified. She is moving to a house in the suburbs, and she is afraid that she is going to be all alone. Now, I remember when I had a baby, and I know that I have experienced murderous rage with my own baby. Every mother has experienced this. I never had a fantasy about killing my baby. There was never any issue of being afraid of controlling myself. But with her, I made a leap that she might be having a fantasy about killing her baby and this was throwing her into a panic. I never had that feeling, but because I had my own feeling -- and my knowledge about the patient -- I knew how she would feel, and what she would be afraid of. So, it was an elaboration of my own feeling, from my own experience, of what it is like to be alone with a baby when it doesn't stop crying. After a certain point you want to kill it. If I hadn't had that experience, I don't think that I would have gotten to what she was feeling so quickly. (#7)*

> *With one patient I wondered why I didn't feel more with her. She was sexually abused. I haven't been sexually abused, but I was in a car accident with my father. And while it is not the same, it pulled on some of the same issues. I couldn't help her to explore how angry she was at her father until I let myself feel how angry I was at my father for hurting me. Until I could feel let down by my father. (#20)*

> *With one patient it really gave me a good sense of empathy. Because I had been through the same type of experience that she had [of coming from a poor family, as she did] I think that I really understood how difficult it was for her. Somebody else might have just said 'What are you worried about? You are smart, you are attractive, you are successful. What difference does it make that you were born poor." I'm not sure that she would have stayed with somebody who didn't really understand her. (#16)*

> *I think it really made a difference that I had had panic attacks myself, in order to help that patient [who had panic attacks]. I don't think that you need to have all the same experiences in order to help somebody, but it does make a difference, and you may be able to stay in the process longer.(#20)*

There was one patient who was having trouble describing the feeling of what it was like to have a crazy, inconsistent mother. Now, that was exactly the kind of mother that I had, and I felt like I knew exactly what she was talking about. So when I started to try to help her to articulate it, she felt that I knew exactly what she meant, and she had never been able to think about it so clearly before. (#11)

I was working in a setting -- an intensive care unit of a medical hospital -- where I felt that I had to prove that I, as a psychiatrist, had to be able to contribute something of some value. I was working with an interesting group of patients, who were on respirators. It was a special group who, from a medical standpoint, were ready to be taken off the respirators . . . They called this process weaning. However, whenever they took these patients off of the respirators, they would go into some sort of distress, like hyperventilation, and the doctors would get anxious and put them back on the respirator, even though all the tests indicated that they didn't need it anymore . . . So, I began to devise a scheme. I saw the patients every day, to try to build up a relationship with them. It wasn't easy, because they couldn't talk much. Then, I worked out a behavior modification kind of plan, using hypnotherapy tapes and such, all of it guided by my analytic understanding. . . And I got results . . . After it worked, I realize that I was identifying with them in a very particular way. When I was 7 or 8, and struggling with asthma, with the feeling that I couldn't catch my breath. I had a visual memory of seeing myself, in my bed, alone -- my mother was in another part of the house. And I was trying things out, experimenting with techniques to help myself breathe. I didn't think about it at the beginning, because I was always observing the patients, but I was identifying with a specific aspect of the patient . . It helped to know what it was like, having that kind of trouble breathing, and I was taking care of the patients the way I had taken care of myself . . . Now that I am talking about it, I am aware of a deeper identification with them, that I only got a taste of at the time. This was the fear that I was going to die, that if I didn't get the air that I might die, or be separated from my mother. (#15)

Most of the examples of useful identifications that therapists described related to experiences that were in-control. However, some therapists also thought that out of control identifications revealed something important about the

treatment -- provided that the therapist was eventually able to bring them under control.

> *Out of control identifications can help because you are usually acting out something which is related to the therapy. If you can fix that, then you can fix the therapy, if you can get enough self awareness and enough supervision. (#8)*

> *If you can analyze the experience and figure out what happened, then you can really get a lot of valuable information about what is happening in the treatment, and understand the transference and the countertransference in a profound way. (#12)*

There were numerous examples of identifications which had initially been out of control but which eventually served the treatment well.

> *I had a patient whose mother died. She was referred to me just after my mother died. Although she [the patient's mother] had died a long time ago, something was coming up in her life that was making her think about it for the first time. My own mother had died about a month earlier. This totally overwhelmed me. Whenever she would cry I would cry. While I found it embarrassing -- I just couldn't stop doing it -- she found it to be really empathic. She said that nobody had ever helped her to mourn her mother. Nobody had ever been emotional with her. But I found it to be fragmenting. (#4)*

> *[The therapist is describing the effects of an identification with a patient which led her to let the patient accumulate an unusually large debt. See pp. 167] The experience with the patient about the money really deepened the treatment. What I have done is to become more firm with her about the money, and this had led to her recognizing a pattern in herself of living from emergency to emergency, and then feeling very entitled to make a lot of demands on other people to help her. I don't think it would have helped if I had been firm from the beginning. She was able to say how she had always yearned to be with somebody who would just let her go with that. Be easy with her on the money. But by really living through it together we got to so much of what her pattern was. It really made it much deeper. (#2)*

> *I was working with somebody that I really was very involved with. I thought we really worked well together. He is*

continually in fights with the people he works with. Now, they are the type of people who would bust anyone's chops. But I was over identified with his need for struggle, with his need to defy authority. . . So, I missed his role in this dynamic. [i.e. the therapist never adressed the patient's own responsiblity in perpetuating this situation] However, if this positive identification [out-of-control identification] wasn't there, it would have been devastating to him. He had been with another therapist who didn't feel that way, and who [the patient felt] was very judgmental, and put him down about what he did, and the treatment didn't work. [The therapist's point here is that if he had not over identified with him in the way that he had, he might not have been able to help him, even though this entailed missing other aspects of the patient's pathology.](#14)

I find these kinds of identifications to be helpful even when they can lead to an empathic break. Recently I was working with a patient who I though had made more progress than she really had. I thought that she was ready for a different kind of interpretation, one that did not grow out of her experience . . . I asked her how somebody else might have felt. I wanted her to be further along than she was. It wasn't right, and she told me so. I think it was because I felt so identified with her and so close to her. She has a artistic background, and so do I. Because I felt so close to her, I wanted her to see the situation the way I did. But she told me what the situation was, and then I understood her better. (#4)

Negative effects

To a certain extent, the more purely negative effects of out-of-control identifications are obvious in all of the anecdotes about out-of-control identifications which have been presented: the therapist is unaware of what she is doing with the patient, and as a consequence, intervenes in ways which either disrupt or destroy the treatment. There is a lot of variation in the types of mistakes that therapists make when they are under the influence of these identifications, ranging from not exploring something carefully enough with the patient to actively -- if unconsciously -- driving the patient out of

treatment. However, therapists also described more subtle ways in which identifications can have a negative impact on the treatment. One way is simply that the therapist loses track of the goal of understanding the patient and communicating that understanding in ways that are helpful to the patient. The therapist loses the distance that is essential to helping the patient.

> *The identifications can have a destructive effect in terms of loosening the boundaries. (#16)*
>
> *In over identification you can really lose perspective on your role, if the feelings and the impulses are too strong to manage.(#18)*
>
> *You start seeing the patient too positively. You stop seeing them objectively. You see them as a victim and you don't see the shitty role that they play in the problems that they are complaining about. You take their enemies as your own, and you run the risk of acting out with them. (#6)*
>
> *It can get in the way when you identify instead of understanding. Treatment goes on longer. You get into a stalemate.(#7)*

Finally, there was another danger involved with identification that therapists mentioned which might be viewed as the opposite side of the understanding that most therapists felt was a major benefit of the process of identification. This was the possibility that the feelings of identification might not be an accurate mode of understanding the patient.

> *I think the biggest problem with identification is when I think I understand something when I don't. (#10)*
>
> *It can become a blind spot, where you assume some sort of similarity that isn't there. (#20)*
>
> *It can blind you to a lot of things. (#7)*

> *When I started, I tended to believe that people did things, or had the same problems, for the same reasons that I did. (#6)*

> *I think there is a danger here in that I think that I know what he is talking about when it is possible that I don't (#12)*

Effect of the failure to identify with the patient

While most therapists reported that identification occurred regularly with most patients, occasionally therapists worked with a patient with whom they could not immediately identify, or encountered a particular aspect of a patient with which they could not identify. The treatment often suffered until the therapist was able to find a basis of identification with the patient.

> *I was working with a woman with an addictive personality. Her problems are focused mostly on borrowing money and spending. We were talking once about how she goes into a fancy store and she can't stop herself from buying something. At first her materialism was a turnoff. What helped me to be with her was to find a part of myself that was compulsive and addictive. This identification stopped me from being judgemental. (#14)*

> *There was one patient who was paranoid. I was really anxious when I was with him. He was all full of conspiracies and things like that. Paranoia is not a feeling that I am particularly prone to have. I almost never feel it. But before his session, early in the treatment, I became very suspicious. I began to look under my desk, out the window, and I wondered if my phone was tapped. I realized that this was rather peculiar. Then I thought of him and I realized that I had found my own paranoia. I hadn't really been able to feel it before. When he came in I was much less frightened. I understood better. (#10)*

At times, however, the therapist is not able to find the identification which will make it possible to establish a link with the patient. The failure to identify can at best lead

to a lifelessness in the treatment, and, at worst, a failure of the treatment with serious consequences for the patient.

> *I had a patient who I found to be vapid, empty. Not, not exactly empty, but so shallow and superficial. Because she was in the mental health field, I think that I needed her to be deeper, and I felt contemptous of her because she wasn't. She was motivated to be in therapy only as an activity, not as a process of self-understanding and change. I worked with her, but I didn't really feel connected to her. I felt disturbed by the course of the treatment. I thought she was a "Valley girl". But if she had been an accountant it wouldn't have mattered. Because she was a therapist I expected her to have an understanding of the therapeutic process. (#9)*

> *I had a patient who had five personalities. I could identify with four of the personalities rather easily. But there was one personality that I could not identify with. She was a rebellious teenager. She had good reasons to be rebellions. She had seen her father shoot her mother. But still, I didn't like her. And she was the one personality that the patient couldn't integrate. (#10)*

> *The patient is schizophrenic. She is, at times, so bizarre that I have difficulty identifying with her, and I think that the treatment has suffered for it. I often lack understanding of her. I grow impatient. I think if I identified with her more, I would be more patient.(#6)*

> *I was treating a very depressed man who had hallucinations of a voice that was always with him. I referred him for shock treatment. It was very helpful in relieving the hallucinations. But he always complained about it. He said that the voice had been his friend and that he was lonely without it. He later killed himself. . . . It was a kind of a lack of identification, in the sense that I really didn't understand what the voice meant for him. (#15)*

For these reasons, the absence of identification with patients was viewed as being problematic, an issue to be investigated.

My philosophical basis is that if you cannot identify with a patient then you are having some sort of countertransference resistance. If not, you would be able to understand. After all, we are all people. When I have that kind of a block, I try to work on it to figure out what is going wrong that I can't understand them.(#18)

If I find that if I can't identify with a patient, I have to ask myself why. After all, we all have the same kinds of feelings, so I should be able to find a point of commonality with anyone. (#17)

A summary of the effects of identification on the treatment process can be found below in Table 3.

Table 3.
Effects of identification on the treatment process

I. Positive effects
   A. In-control identifications
      1. Provide a good general background for understanding the patient
      2. Provide information for understanding very specific problems that the therapist might not otherwise understand.
   B. Out-of-control identifications
      1. Provide valuable information about the treatment, provided that the therapist can eventually bring them under control.

II. Negative effects
   A. Lead to making inappropriate, potentially destructive interventions.
   B. Loss of perspective; diminished ability to see and understand the patient within the broader context of his life, leading to therapeutic stalemate.
   C. Mistaking feelings of identification with the patient for understanding; thinking that therapist understands the patient, when in fact, they do not understand the patient.

III. Failure to identify
   A. Treatment stalemates until therapist is able to find a basis of identification
   B. Treatment fails as a result of the therapist's failure to identify with the patient

WHY IDENTIFICATIONS GO OUT OF CONTROL

The question of why some identifications remain in control and why some go out of control is complex. For a number of therapists, the main issue is whether they are aware that the identification was taking place. If they are aware of what was happening, then they are able to control it. Conversely, if they are not aware of it, it tends to go out of control.

> *For me, the main issue is awareness. If I am not aware of the identification, it is out of control. (#1)*
>
> *It is negative [the effect of identification] if you are not consciously aware of it (#18)*
>
> *A lot of my ability to control it depends on having a more developed observing ego. Then, it is more under my control, more conscious. (#10)*
>
> *As long as I can become aware of the identification, as long as I can catch it either myself, or in supervision, then I can use it for the treatment. (#10)*

Therapists also suggested that, in addition to the question of awareness, part of what enables an identification to remain in control has to do with the therapist's degree of comfort with and acceptance of the feelings that they are identifying with.

> *These experiences become a problem for the treatment when the therapist can't look at it and acknowledge it, within themselves. Then it escalates and it becomes a major, almost characterological problem in the treatment Then the treatment is in trouble. But if you acknowledge it then you learn more about the patient. and your relationship. (#3)*
>
> *A very important factor, in terms of managing the identification, in addition to being able to identify, is for*

the analyst to be at a point where they have some understanding or acceptance of the behavior or dynamics, within themselves. This is not to say that I would condone behavior which was destructive to the patient or to others, but that I might understand, for myself, why I might persist in the behavior even when I knew that it was destructive. So it is not just the identification which is important in the stance. It is understanding versus self control. Initially, with that patient that I described, I did not have any self acceptance about those aspects of her that I was identified with. (#17)

RECOGNITION OF UNCONSCIOUS IDENTIFICATIONS

A crucial aspect of therapists bringing out-of-control identifications under their conscious control is the recognition that an identification is taking place. As the numerous examples of out-of-control make clear, it is often extremely difficult to arrive at this recognition. One way that therapists were sometimes able to recognize identifications that they were unaware of was through self-reflection. In these cases, they looked for or noticed certain peculiar features about the ways that they were feeling towards their patients, or deviations from the way that they usually related to patients in general. However, these peculiarities were often quite subtle, being just slight exaggerations of their normal thoughts and feelings about the patient. One therapist referred to her "baseline". In the following examples, therapists noted departures from that baseline.

I first noticed it when I realized that she really started to accrue a bill. I'm generally a little soft on money matters, but this was too extreme. What I did with her was unusual. (#2)

I started to get bored in the sessions, feeling like we had been here too long. And I realized that I was taking too much interest in her parent's experiences. It was almost perverse curiosity. It seemed too compelling. Yes -- it was the increased interest that clued me in that something was wrong. (#7)

I think that an intense identification with somebody is a clue that something is getting out of control. (#15)

What tipped me off to what was going on was how much I was thinking about him, how I kept replaying the sessions in my mind. How often I wanted to think about him. (#14)

One therapist gave an example of how she was gradually able to recognize and control a particular type of symmetrical identification which certain patients aroused in her during terminations.

There was a patient that I was working with around termination. She kept making references to homosexual ideas -- not her own, but to other people's. She had never discussed this before. I belived that it was the termination that was stimulating this. I think that it was related to her feelings about me. I just recognized this, I didn't have the feelings myself, and I didn't explore it with her, as that would not be appropriate in the context of the type of work that I am doing with her. However, the same type of thing happened with other patients in the past when I was terminating, but I wasn't in control of it. With another patient I began to have sexual feelings about her. I knew that it wasn't coming from me, because I had never had those types of feelings about her before, and I really didn't like her that much. But still, I noticed what she was discussing, and what I was feeling, and I began to explore it with her. This happened with another patient as well. Although I knew that I was having these feelings about her, I didn't realize how seductive she was until she brought her brother in for a joint session and I saw how inappropriate she was with him. It was always around termination. So, this most recent time, I was able to simply observe it without actually getting involved with it on an emotinal level. You see the same thing happen with a few people, in the same types of situations, and your realize that this is a common dynamic, and you can stop it before it gets out of control. (#9)

Occasionally, it was the patients themselves who alerted the therapist to the possibility that something was going wrong in the treatment. In these cases, the therapist was oblivious to their out of control behavior, but the patients were not.

> *A couple of weeks ago it happened with a patient that I have been working with a long time. We have a very good rapport. He is a very defensive guy, and usually I respect the defenses. I feel they are there for valid reasons. But at times I get very impatient with him. There is an aspect of his personality that is depressive, in a passively suicidal manner. He would never do anything active, but he starts talking about things that could happen, and that would be OK. Recently he got into that state, and I acted out of control. I told him flat out that I didn't believe it. That if he really felt that way he wouldn't be talking in that way. I was very challenging and confrontive. Now, you have got to understand that that is really not my style of working. The next week he came in and said "What was with you? What was wrong last week?" I realized what had happened. I have had those feelings -- those passively suicidal feelings -- in the course of my life. It is not often. Mostly I feel that life is too precious to waste even a half a second. But those feelings are a tiny part of me. But his feelings were touching on that tiny part of me and I was reacting to it . . . My response was kind of a defense against having those feelings. But I didn't realize it until he confronted me. Even thought it was completely out of style for me, I just put it away. I didn't think anything of it.(#1)*

> *A patient often talks about his parents. He's always laying into them. I always went along with it. It made perfect sense. Then once he said to me that I didn't have children. I asked him why he said that and he told me that whenever he talks about his parents I always identify with him, never with them. I didn't realize it until he told me that. And I thought that I was doing genetic interpretations. He was right. (#4)*

Finally, therapists found that they could frequently be helped to recognize identifications in their personal therapy and supervision.

> *I realized it in my analysis a couple of weeks later. My analyst asked me a couple of questions. Not to say that I was wrong, but they pointed out that I wasn't acting like an analyst. That was enough to get the case back into control. (#6)*

> *Sometimes I can identify with a patient and not know it until I present the case in supervision. There was one patient that I presented at length to my supervisor and he said, "Don't you ever get mad at the patient?" And I said that I did, but that it was a cold anger that barely showed at all. After we talked about it I realized that that was what her anger was like. Very cold. I was acting and feeling like she did. That wasn't in control. But once I became aware of it I was in control again. (#10)*

> *I have an obsessional patient who is filled with rage and depression. But he has a very muted experience of it. His affect is very flat. When I present the session in my supervision the feeling that I have is flat, affectless, dry, and obsessional. My supervisor will pick up the feeling that I have defended against, put it into words, and I will feel it. Its fascinating. . . . I identify with the defense, and, on a deeper level, the feeling. She interprets the defense, and I feel the feeling. I can carry this around for several days, and then when I come into supervision it is as fresh as it is with the patient. (#13)*

FACTORS WHICH LEAD TO IDENTIFICATIONS GOING OUT OF CONTROL

Characteristics of the therapist and the patient

Most therapists were aware of a number of different factors which might lead to identifications going out of control. Specific characteristics of either the therapist's personality or the patient's personality were the factors which were most frequently mentioned. Perhaps the most common were the therapists' personal idiosyncratic reactions to particular dynamics, issues, or types of patient behavior. These issues were highly subjective, and varied considerably from therapist to therapist. The common theme in the examples below, therefore, is not the individual issues described, but

rather the fact that most therapists recognized personal and idiosyncratic issues that could lead them into out-of-control identifications.

> *It also happens with patients with whom I would like to be friends. That helps the identification to get out of control. . . It also happens with patients with rigid defenses, especially denial, then, I might get an identification with them. And when I have a great need for a patient to see something. Especially abusive situations. Dynamics in a relationship where it appears that the person is being abused. I identify both with the denial and with the struggle against it. (#1)*

> *I am probably most prone to identifying with depression. I can be caught up in the feeling of hopelessness and helplessness. Sometimes when I am with a depressed patient I pick up those feelings, and I feel blocked in the session. I can't think of what to say or what to do. I feel like a fraud, like I shouldn't be treating these people. Like I didn't know what to do. But it is mostly with depression, as I tend to be depressive myself. . . .And with narcissistic patients I tend to think a lot about myself, often in really petty ways. Like what I am going to have for lunch, and can I get to a restaurant. (#18)*

> *There are certain feelings it happens most often with. Obsessing, in particular. (#3)*

> *If they are obsessional, then I can be. After all, that's one of the things I get into. (#20)*

> *The most difficult times are with patients who are rejecting, and then I get rejecting. (#13)*

> *If a patient is sick up to a certain point. If they have an intensive (sic) personality disorder, up to the point of being psychotic, I have a tendency to over identify. Once they are psychotic they are over the line, and I don't identify so much. (#6)*

> *I also have strong reactions to narcissistic patients -- the classic type, who are so entitled and grandiose. I had a copy machine in my office. She asked me casually if I could make a copy of something for her, as if she had a right to it. I felt like I wasn't even being asked, that of course I would have no objection. I felt completely enraged by that. . . I think it is because I would like to be able to feel that*

way, to act that way, but I don't allow myself to. I want to be as entitled as the patient is. (#8)

I have trouble with patients who are involved with a lot of impulsive action. That's my own weak point. (#11)

Whatever issues that I have that aren't cleared up with is what I have trouble with. People who make pathological attachments. People who have some fear of abuse in childhood, with unpredictable, narcissistic parents. (#9)

Mostly I identify with conflicts with their parents. Less with their conflicts with their children because I don't have children. (#4)

In addition to completely idiosyncratic areas of vulnerability among individual therapists, there were also some themes that emerged in a number of therapists. One area that some therapists reported as a potential source of difficulty in managing identifications was the situation in which there were real similarities between the therapist and the patient. While areas of similarity that the therapist is comfortable with or resolved about don't usually create difficulties, areas in which the therapist is unresolved can often lead to out-of-control situations.

Real commonalities have a lot to do with it getting out of control Especially the distressing parts, and the concrete similarities.(#1)

If someone has a similar history to mine that almost automatically sets up an identification. That almost never changes. It happens mostly in terms of my expectations. That is, if they have the same history as me, I expect them to be able to make the same kinds of accomplishments that I have. This is an area I constantly have to watch for. (#4)

Commonalities that are based on issues that are resolved don't go out of control. If it is attached to an issue that is unresolved it can go out of control.I usually identify with general qualities in my patients that are similar to my own.

It is not the details so much, but the general features of their backgrounds. (#16)

Real similarities between myself and the patient are a big part of it. As is any part of my own conflicts which are unresolved. (#2)

This patient is also a patient who was in the same field that I was in before I became a therapist. She is nice, conscientious, all the things that I would like to think I am. . . I find myself more willing to capitulate to giving advice with this patient, even though I know that it is what she is unconsciously seeking. I assume that she is like me, and so I treat her more as a friend, and as I would like to be treated, than as a patient.(#19)

Another set of factors that therapists described as leaving them more vulnerable to identifications going out of control included specific dynamics or issues that patients brought into the treatment. One dynamic that seemed to be particularly contagious was paranoia.

It happens with paranoid patients. I go out of the office looking over my shoulder. My lover looks at me, either complementarily or neutrally, or, in any case, not with hostility, and I ask "What are you looking at? What, am I fat or something?" It probably happens a lot more, but unless it is really extreme I don't notice it. (#8)

It occurred with a borderline patient with whom I was terminating. She was getting psychotic and paranoid. . .She constantly had thoughts of one or the other of us being executed.. . . After working with her I would sometimes start laughing at myself. Or, when I was walking to the parking lot, I kept looking back over my shoulder to see if someone was following me. I was really getting paranoid, the way she did. I recognized what was happening immediately, and it felt distant, ego dystonic. But still, it was something that was happening to me. (#19)

One patient was very secretive, and was terribly worried about people's good opinion of her. She was always afraid that people were saying terrible things about her. Eventually she left me, and whenever I thought about her, I became afraid that if people knew about my treatment with her it would ruin my reputation. (#11)

One situation in particular freaked me out. It was with a manic depressive patient. He was very angry, and very suspicious. He sort of stormed into my office. He is a gambler, and he seemed very desperate to me. I was concerned that he would do something desperate, just with the way he was talking to me, and I was trying to establish some sort of control over the session. When it came time to pay me he sort of pulled out his wallet, paid me in cash, and then shot out the door. Then I realized that he had gone into my office before I had. I had been in the bathroom, and he was in my office alone. I started to look for my wallet, and I couldn't find it. I looked at the wad of cash and I thought that he had stolen my wallet, and was paying me with my own money. I had the thought that I would run after him and stop him, but fortunately I though the better of it. I calmed down and found my wallet. And I realized that it was his paranoia. That I had caught it. And again I had the feeling that he was really in a state to do something desperate. The intensity really scared me. I didn't act out, but I almost did. (#3)

Another dynamic which, less commonly, appears to be provoke identifications which are difficult to manage is dissociation.

It also happens with dissociative disorders. It is easy to get drawn into the patient's dissociative process. I go into a sort of fugue state. (#18)

This was sort of an enactment. There was a patient that I was getting very drowsy with. Usually, given the way I work, I would bring that up with the patient and tell them that I was having an unusual feeling, and ask them to help me to understand it. But I didn't want to bring it up with her. I wanted to hide it, and just pretend it wasn't happening. But she confronted me with it. At first it seemed like an enactment of her alcoholic father, who used to fall asleep with her, and she was afraid to leave him alone . . . But after we had discussed this, I couldn't believe it, but it happened again. I discussed it with an analyst who did a workshop, and he suggested that she was lulling me to sleep with her voice. Then, it seemed like a kind of dissociation. She had been blotting out the feelings that she didn't want to experience in the therapy. And we began to see how she was lulling both of us asleep. She did that a lot --lulled herself into a drowsy state to avoid feeling the pain. I played out a piece of her. (#20)

Aspects of the treatment process.

Certain situations within the treatment process itself can sometimes give rise to identifications which therapists have difficulty in controlling. One factor, which seems to vary among therapists, is the phase of treatment. For most therapists, the middle phase of treatment is the one that is most stressful in terms of experiences of identification. This phase, which would in most cases constitute the greatest segment in a long-term case, would be the phase following the initial engagement, and prior to the period leading up to termination. Therapists cite both the inherent intensity of this phase of treatment, and the tendency to to let their guard down.

> *it gets out of control mostly with patients that I have been working with for a long time. Like with the patient that I described, we have a very deep bond. Then, I'm not so aware of the risk. I let down my guard. It is not a conscious thing. (#1)*

> *It happens most in the middle phase of treatment. That's what the middle phase is! The relationship is more intensified, and everything in it is more intense. (#2)*

> *The middle phases of treatment seem to be the most difficult, when the transference and the countertransference heat up. And I tend to let my guard down. At the beginning I tend to be careful, to keep a certain distance. As the treatment develops I tend to let my mind wander. (#5)*

> *I find that it occurs most when the patient has been in treatment for a very long period of time. Then, I tend to loosen the boundaries. Usually, I'm not loose, but it happens. Sometimes I think it is just sloppiness. I'm just less respectful about the need for boundaries. (#16)*

> *There has to be a sufficient connection with the therapist for this to occur. Or, its just easier to recognize after you have a baseline with the patient. You know what you are like, you know what they are like, and you can tell when things are*

different. It has happened in the first interview, but I don't think that I realized it until afterward.. However, I do think it is more likely to happen when you have reached a level of greater intensity of feelings.(#19)

It's the worst in the middle phase, after we have really gotten attached. (#6)

Although most therapists described the middle phase as being the most stressful, for others it was periods in which the patient wanted to terminate that created the most difficulties.

It is especially difficult during treatment destructive periods, when the patient might actually leave. If a patient is securely in treatment, I don't get so out of control.(#8)

I think it occurs most often during the ending phase of treatment, when I have to be more aware of the importance not to interfere with the patient's autonomy. It also occurs at the beginning of treatment. In fact, it is when dependency issues are most strong, either at the beginning, or at the end, that things get the most difficult with identifications. When the patient is engaged in treatment it does not feel out of control (#3)

When a patient wants to leave treatment is very easy to get out of control. It can happen in a very subtle way, so that superficially I am doing what I am supposed to keep the patient, but on a deeper level I am doing exactly what it takes for them to leave. . . When a patient is rejecting, it is almost irresistible not to be rejecting.(#13)

Another aspect of treatment which can arouse intense identifications involves the payment of fees. Here, the problems are not related to a specific dynamic. Rather, the need for therapists to collect their fees from patients who are resistant to paying seems to arouse a number of different but related feelings.

It happens all the time with money issues. A patient asks me if they can pay late, or if I can lower the fee, or if I will

treat them for free. It's always something to do with feeling deprived, and wanting me to take care of them. And my feeling often is the same: Who me? Can't you see that I'm so broke I'm starving to death? (#11)

There was one patient that I was having trouble with around money matters. She wasn't paying me, it was going on and on, and I wasn't confronting her. She was always having crises in her life. I was identified with her. She was a single parent. She was broke, and she was overwhelmed all the time. At the beginning it wasn't conscious. Then it vacillated. Sometimes I was, and sometimes I wasn't. But I still had a great deal of difficulty bringing it up with her. It was very much an induction. Her parents were very self indulgent. They would buy expensive furniture, while the kids didn't have any underwear. It started to pull some of my own stuff, feeling deprived like that. (#2)

There was a patient that I have been letting down the boundaries with. That is not my style. I usually keep very strict boundaries. And one of the things is that I have let her accumulate a large debt. At the same time, she has become quite demanding, quite entitled, as if I owe her more and more. I guess I identify with her in that I remember when I was going to school, and I didn't have much money, and my therapist treated me for a very low fee. But I was really appreciative, and I tried hard to do everything right. Now, that was a treatment issue for me. But because I identify with her I have been expecting her to act the same way I did -- appreciative and cooperative. But she is not being a 'good patient'. She is asking for more, not less. In fact, she is being a real pest. And so I am disappointed that she is not living up to my expectations of her, which are based on my identification. (#16)

FACTORS WHICH HELP THERAPISTS REMAIN IN CONTROL OF IDENTIFICATION

Most often, the factors which helped therapists to maintain control of identifications related to their on-going personal and professional development. The most common factor which was cited was their amount of experience in the field. However, it should be noted that in most of the following comments, the improvement that occurs with experience is not

that therapists identify less frequently or less intensely, but that they are more able to do so consciously, with a degree of awareness and control that was not possible in the beginning.

It was harder to sort out at the beginning. (#3)

I feel more control over it now, although I can't say that it happens any less or that it is any less intense. (#4)

I may be a little sharper at picking these things up now. I also feel more self acceptance. I don't hate myself so much when I recognize it.(#2)

With experience I get much quicker at being able to see what is happening and then able to metabolize it, to put it into words and control it. (#19)

I think I am more aware of the identifications happening now. I actually think that I probably identified more often when I first started it, but I am more mindful of it now, so it seems like I am doing it more. I have been practicing now for long enough to know what is typical for me with a wide variety of patients. So I know when something is different. (#16)

Experience helps -- absolutely, in a lot of different ways. The more experience I have the more I can consciously identify. I think that analysis and supervision have made it possible to have the experience more consciously -- and the more conscious it is, the more I am able to control it. (#13)

The amount of experience makes a huge difference. It is much easier to be reactive when you are experienced. It allows you to identify without getting over-involved. (#7)

Professional experience helps tremendously. Every year it becomes so much easier. I used to have to allow the identification to occur, it didn't happen naturally. And I think that [earlier in my practice] a lot more of it was unconscious, and out of control.(#10)

When I first started the identifications were very powerful, and I would identify with every aspect of the patient's personality. Now, they are less powerful, and I am less inclined to identify with all parts of them, and less inclined to believe that they are like me, when they are not. (#6)

Another factor that therapists found to be useful in controlling identifications was theoretical awareness of the phenomenon -- the recognition that this was an expectable and desirable aspect of the therapeutic process.

> *The theoretical understanding helps me a lot. For example, if I am feeling very critical of myself I begin to think in terms of projective identification. I think that maybe the patient is feeling that way. When somebody starts accusing me of judging them, and I do feel somewhat judgmental, I begin to think that they are judging themselves. (#3)*

> *Part of what affects the analyst's ability to be aware of the issue will depend on how much -- conceptually -- they look for it. (#17)*

> *Theoretical awareness is also very helpful. For me it has prevented me from identifying and allowed me to understand instead. The self psychological literature helped me to understand things that I didn't understand before. Before, I might have identified. After all, identification is a defense. You have more problems with it when you don't understand. Then, you are not in control. (#7)*

> *What has helped is the recognition of the existence of identification, a recognition of its possible therapeutic consequences. It helps me to be aware when something doesn't feel right, or when something in the patient might touch off something unresolved in you. (#14)*

Some therapists, however, felt that theoretical awareness of the phenomenon of identification, while helpful, was secondary to the problem of coming to terms with the feelings on an emotional level.

> *Theoretical awareness helps a lot. When other defenses fail, theoretical awareness really bolsters your intellectual defenses, which can get you through it until you can deal with it more profoundly. (#8)*

> *Theoretical awareness helps to a certain extent. But what really helps is developing a tolerance for the feelings on an emotional level.(#13)*

What facilitated this process for most therapists was their own personal therapy and supervision. Interestingly, while almost all therapists agreed that personal therapy was an extremely important factor in helping them to manage identifications (although some rated it lower than supervision) few were able to elaborate on this. Some made general comments about knowing themselves better. Therapists' awareness of their idiosyncratic areas of vulnerability (pp. 150-152) was often described as a result -- at least in part -- of therapy. However, the interviews did not capture data on this issue in any significant detail. Part of the reason may have been that the interviewer was hesitant to explore therapists' personal therapy on anything more than a superficial level; it was often felt that the interviews were already pushing the limits of what the subjects could comfortably reveal. Nevertheless, a few examples were obtained.

> *Therapy helps most in understanding your areas of vulnerablity, so that you are aware of them when you run into them. (#18)*

> *My analyst is especially good at it [helping with identifications] when I am feeling helpless and hopeless. (#11)*

Therapists were able to describe specifically how supervision helped them to both recognize and manage identifications, and also some of the types of supervisory

interventions that therapists find to be helpful in managing and controlling identifications. These consist of interpretations of what is taking place with the patient and questions designed to point out to the therapist that something out of the ordinary is happening. In all of these examples, the supervisor's interventions were rather gentle. Direct confrontations do not appear to be called for. In fact, what most therapists found to be particularly valuable in the supervisory setting was the supervisor's acceptance of their feelings about and with the patient.

> *The best interventions are ones where the supervisor just asks questions about what happened. Not, "What did you do?!" (#12)*

> *I really need to be in a supervision where you can talk about your countertransference, where it is accepted that identifications happen, and that they are important and that they are valuable. I wouldn't want to be in a supervision where that was not the case.(#2)*

> *A supervisory group in which you have the opportunity to share with a group of people some of the worst feelings you can have as an analyst. Being able to talk freely about yourself, about the feelings that you are not doing a good job, and not being helpful. It has to be a supervision that focuses on the therapist's experience as well as the patient's experience. (#14)*

> *An accepting supervision, one which is open to discussing and accepting all of my thoughts and feelings about a patient. (#13)*

> *When they (the supervisor) see what is going on they will make interpretations about how it relates to my own life . . . I have always worked with supervisors that I can be very open with. They know my personal history as well as my clinical history. So, when they see things like this happening, they can make interpretations about it, and that is very helpful. (#4)*

THE EFFECT OF THE REASEARCH INTERVIEW PROCESS ON THE SUBJECTS

Perhaps the least fruitful area of investigation of this subject was in understanding the effect of the interview process on the subjects. A few therapists found it to be an extremely valuable process.

> *It really put the whole importance of this process into perspective for me. (#3)*

> *I spent a lot of time thinking about this before I did it, and I must say, it really made me understand my practice, and the way I relate to patients, in a very different way. The concept of identification is not one that I utilize most of the time, but when I considered it I realized the way it girded my whole mode of doing therapy. (#14)*

Indeed, most therapists described the experience as being interesting, thought provoking, or in some way important. However, the extremely enthusiastic responses, such as those cited above, were the minority. By the end of the interviews, most subjects appeared to have said as much as they could, and did not appear to be willing or able to go on to actually reflect on the effect that the interview process had had on them. I had the impression that many subjects found the interviews both exhausting and stressful. And, as I noted in the interview process, many therapists appeared to be somewhat uncomfortable about describing any of this material in any detail. From this perspective, I feel that I was fortunate to be able to obtain as much candid material as I was able to get. However, it had the consequence of having the interviews end on a rather abrupt note. When I asked how the interview

process was for the subjects, most gave me rather clipped and overly polite responses.

It was fine.

Happy to be able to help you.

No problem.

My sense was that they did not want to say any more; in most cases, they seemed more than ready to end the interview.

Interestingly, after the interviews, I heard, second hand, that a number of the subjects had been saying that they had found the experience to be extremely meaningful, and that it had clarified many aspects of their work for them. However, I did not feel at liberty to call people back and do any follow up. All of the subjects were extremely busy, and arranging the time to be interviewed was quite difficult for nearly all of them. It did not seem reasonable to ask them for any more time.

Consequently, it was not really possible to determine the effect of the interview process on subjects, except to make the general comment that while they found it interesting and thought the subject was important, they did not feel altogether comfortable in discussing it.

DISCUSSION

Summary of the analysis

In the course of this study, twenty (20) psychotherapists were interviewed about their experiences of identification with the patient. All therapists agreed that the identification with the patient was a central -- and essential -- element in the therapeutic process. All therapists said that they identified frequently with the patient's feelings, and some reported that they identify in equal measure with the patient's behaviors and thoughts. Most therapists viewed identification with the patient as a pervasive experience in psychotherapy.

Four different types of types of identifications were found in the data: simple identifications, chronic identifications which involved the therapist's whole identity, symmetrical identifications, and projective identifications. These were defined as follows:

Simple identification: Identification in which the similarity between the therapist's thoughts, feelings, or behavior and the patient's thoughts, feelings, or behavior is clear, straightforward, and obvious. In-control simple identifications correspond to what is described in the literature as transient identifications or empathy. Out-of-control simple identifications are an important part of what is described in the classical psychoanalytic literature as countertransference (Reich, 1959).

Chronic identification: An on-going identification in which the therapist consistently views or experiences the patient as having thoughts, feelings, or behavior that are similar or identical to the therapist's own thoughts, feelings or behaviors, and in which the therapist's identify appears to be similar or identical to the patient's identity.

Projective identification: A state in which the therapist experiences a thought, feeling, or behavior which she believes to be a aspect of the patient's personality that the patient is neither aware of nor consciously experiencing.

Symmetrical identification: A state in which the therapist has the same feelings for the patient that the patient has for the therapist.

All types of identifications were found in both in-control and out-of-control manifestations. Identifications were reported to occur most frequently while the therapist was with the patient, but were also manifested in the therapist's personal supervision and in her outside life.

While most identifications were transient and partial in nature, others were enduring. The identifications ranged in intensity from mildly pleasurable feelings of understanding the patient to powerful experiences of paranoia, impulsivity, and inappropriate behavior.

Most therapists reported that identifications could have both positive and negative effects on the treatment. Most therapists agreed that in-control identifications served the

treatment by helping them to understand the patient, either in a general way or by helping them to understand very specific issues. Therapists reported that out-of-control identifications could also serve the treatment, provided that the therapist was eventually able to bring the identification under control and discuss the effects of any inappropriate interventions with the patient.

Therapists reported that identifications could negatively affect the treatment, either by creating a false sense of understanding the patient, or by leading the therapist to intervene in disruptive and inappropriate ways. The inability to identify with the patient was viewed as a possible cause of treatment failure.

Many therapists suggested that a lack of awareness that an identification is occurring is the major reason that identifications can go out of control. Other therapists added that an identification is more likely to go out of control if the therapist does not herself accept the feelings that she is identifying with in the patient.

Therapists reported that a number of factors may alert them to an identification that they are not initially aware of. Some therapists analyze any departure from their normal and habitual ways of thinking, feeling, or functioning with a patient to determine whether an identification is occurring. In other cases, the patient has pointed out such a departure to the therapist. Finally, most therapists found personal

therapy, and especially supervision, to be helpful in recognizing identifications.

Therapists identified a number of factors which lead to identifications going out of control. The most common factors were personal areas of idiosyncratic vulnerability. These areas of vulnerability varied from therapist to therapist. Some therapists noted that real commonalities between themselves and the patient -- especially areas that were unresolved for the therapist -- increased the chances of identifications going out of control. Some therapists also reported that identifications were more likely to go out of control with paranoid and dissociative patients. Therapists reported that identifications can become difficult to manage in all phases of treatment, with some experiencing more difficulty in the middle phases, and others at the beginning and/or ending. Issues around the payment of fees also stimulated out-of-control identifications.

Therapist also identified factors which helped them to keep identifications under control. The most frequently mentioned factor was professional experience. Theoretical awareness was also a common factor. Most therapists agreed that personal therapy and supervision also helped them to manage identifications. Therapists noted that supervision that was accepting of identifications, and in which they felt free to discuss emotional reactions to patients, was crucial to the effectiveness of the supervisory process.

Flaws and limitations of the study

Some of the significant limitations of the study were those that are common to all qualitative studies: it did not test a hypothesis, nor did it generate results which could be retested through replication. While the study describes phenomena which may occur in other populations, it does not permit statistical generalizations to other populations.

In addition to the general limitations that are characteristic of the qualitative methodology in general, the study had a number of limitations that were specific to the study itself. First, the study was limited in the data that could be collected by two factors. First is the factor (previously mentioned) that many therapists were concerned about protecting their privacy. As has been noted in the section on Methodology, therapists in this study were, on the whole, more concerned about privacy, and more defensive about revealing information, than those that had been interviewed in the pilot study. At times, I had the impression that some subjects were withholding examples of identification, or omitting details of the experiences. This may account for the fact that some of the anecdotes collected in the pilot study described more extreme examples of out-of-control behavior on the part of the therapist than those that were collected in the present study.

Thus, while the study amassed a significant number of examples of identifications -- including some that had not

been previously described in the literature -- there is no doubt that it does not present a complete picture of this phenomenon, even within this limited subject population.

My impression is that the primary reason that some therapists were more reticent in this study than in the pilot study was that I did not have as close a relationship -- either personal or professional -- to many of the therapists in this study as I did to those in the pilot study. This suggests that this type of research requires an unusually high degree of trust between the interviewer and the subjects.

On the other hand, it is possible that a researcher who was completely unknown to the subjects might be in a better position to help therapists overcome issues about privacy. However, my experience suggests that it might be more difficult to obtain subjects for such research; none of the potential subjects who I approached about participating in the study but whom I did not know personally were willing to be interviewed.

Another limitation of the study, again related to data collection, was the fact that many occurrences of this phenomenon apparently occur outside the therapist's awareness. Obviously, identifications that the therapist never became aware of could not be included in a study of this type. Thus, the study was limited to those examples that therapists were aware of, either at the time that they occurred or after the

fact. Again, this represents a limitation on the type of data that could be collected and analyzed.

It is possible that this problem could be ameliorated by preparing subjects for the process in more depth than was done in this study. For example, the interview process might consist of two interviews: the first interview would serve to both help the subjects to become more comfortable with the interviewer and to discuss, in detail, the type of material that was being sought; the second interview would go into the material in greater depth. Another possible way of preparing subjects would be to send them examples of the anecdotes that have thus far been collected, in order to make them more aware of the experience and to stimulate their memory.

Relationship of the findings to the literature

The examples of identifications collected in this study include every type of identification process that was described in the literature on identification, empathy, and countertransference. The in-control simple identifications can be seen as clear manifestations of empathy, as it is described by Greenson (1960), Arlow (1963), and Arlow and Beres (1974). Some of the identifications which were helpful in a specific way illustrate Freud's (1912B) idea that the analyst makes use of her own unconscious to understand the patient. Most of these types of identifications provide the

kind of close understanding of the patient that Kohut (1959) views as being essential to treatment.

While many of the simple identifications exhibit the well tempered level of intensity that these authors describe, others exhibit signs of the desperate struggle which characterizes Fliess's (1942) account of identification. Furthermore, the examples of out-of-control simple identifications make clear that identifications become a danger situation for the therapist. They are clear examples of the possible dangers of countertransference as described by Reich (1951).

Examples of projective identification, consistent with the discussions of this phenomenon (Grinberg, 1962; Ogden, 1979) - both in in-control and out-of control manifestations -- were collected in this study. Similarly, examples of parallel process in which the therapist actually behaves like the patient, consistent with much of the literature on the phenomenon, were also collected in the study, in both individual and group supervisory settings. Examples of the type of parallel process which is described by Eckstein and Wallerstein (1958), in which the therapist's own problems are expressed with the supervisor in such a way that makes it appear as if she is behaving like the patient, were not found in the study. However, numerous therapists described the danger of assuming an identification with the patient when there is actually no similarity between themselves and the

patient is reminiscent of the type of process that Reich (1951) describes.

Two types of identification that have not been previously described in the literature were collected in this study: the chronic, on-going identification in which the therapist's entire identity becomes bound up with the patient's identity; and the symmetrical identification, in which the therapist has the same feelings for the patient as the patient has for the therapist.

The chronic on-going identifications which involve the therapists whole identity are of interest because they may have an important role in the therapist's development and consolidation of her professional identity. It is possible that the experience of having a patient with whom the therapist identifies so closely serves as a kind of testing ground in which the therapist comes to understand the ways in which she can be similar to a patient, how she can still be different. Therapists experiencing these identifications reflected on how their own needs for treatment were similar to and different from those of patients who they experienced as being almost identical to themselves. An on-going chronic identification of this kind might be an important place in which a therapist learns to manage the experience of identification in general. Although only a few examples of these types of identifications were collected, it is possible that these would be more prevalent if the interview were

focused specifically on this type of experience. It is possible that many therapists have a specific case in which they worked out a number of important personal and professional issues, and that identifications play and important role in this situation.

The symmetrical identifications are of special interest both because they appear to be difficult to detect, and because they have the potential to wreak havoc in the treatment. For example, a therapist might respond to a patient who is having intensely negative feelings towards her with equally negative feelings towards the patient. If the therapist were unable to understand this experience as a type of identification, she might be inclined to act-out on the feeling by rejecting the patient for treatment, either unconsciously, or consciously rationalized as ethical decision based on the consideration that it is not in the patient's best interest to be treated by a therapist who has such intensely negative feelings towards him. Indeed, symmetrical identifications may be harder to detect and manage than projective identifications because there is not the obvious disparity between what the therapist is feeling and how the patient is acting or feeling. Furthermore, the lack of literature addressing this type of dynamic may suggests that therapists may be less aware of it than other types of identifications.

Another manifestation of identification that was picked up in the study, and that has not been previously discussed in the literature, is the spill-over of identifications into the therapist's personal relationships with her partner or children. Although therapists did not describe any serious or permanent problems resulting from this experience, this type of identification clearly has the potential to have a very disruptive effect on the therapist and the therapist's family members. This is an aspect of the stress involved in the practice of psychotherapy that has not been adequately recognized or discussed.

The degree of defensiveness that I encountered strongly suggests that experiences of this kind are not something that therapists have become comfortable in admitting or acknowleding, even to their peers. Although attitudes about countertransference in at least some of the literature have become more accepting of countertransference than when the concept was first developed, the experience of this researcher is that the notion that countertransference represents a type of flaw in a therapist's ability to practice remains strong, and continues to inhibit the open discussion and exploration of the experience of identification with the patient.

Overall, the study suggests that the therapist's identification with the patient is an even more complex and pervasive phenomenon than the literature portrays. While this study, being qualitative in nature, was unable to establish

the frequency of identifications in treatment, therapists in this study reported that identifications occur regularly, and that treatment does not work as well without it.

Identification and other forms of countertransference

Furthermore, a sense emerged from the study that the examples of identifications which therapists were able to remember and describe represented only a small number of the experiences of identification that they had actually experienced. Many therapists commented that "this type of thing happens all the time", but that they were not always able to really recall what happened. Another therapist said

> *It's as much a part of the therapy as learning how to move your legs and body is in balancing a bicycle. However, you can't really describe how to do this, except in a general way. It just becomes part of the way that you are when you are doing psychotherapy. (#15)*

This is not true of all forms of countertransference. Indeed, one of the difficulties encountered in the interview process was that therapists often described examples of other types of countertransference -- in spite of the fact that they had received a copy of the interview guide several days prior to being interviewed.

The reason for this may relate to the idea that in the types of countertransference in which the therapist experiences the patient like a significant person from her own past, the patient is viewed as being a distinct and separate person from the therapist. On the other hand, in

countertransference based on identification, the therapist views the patient as the same as herself, even a mirror image of herself. It may be harder for a therapist to recognize when she is dealing with a reflection of herself than when she is obviously dealing with a distinct person - however distorted this latter perception might be. Except for the simple identifications that the therapist is both aware of and in control of, the study suggests that identification is a shadowy phenomenon that underlies much of the experience of practicing psychodynamic psychotherapy, only occasionally remaining in conscious awareness if it is not specifically focused upon.

Implications for the training and supervision of social work psychotherapists, and recommendations for supervisors and agencies

This study has clear implications for the practice of clinical social work, particularly in relation to the training and supervision of beginning social work clinicians.

1) The experience of the therapists identification with the patient can be a significant factor in clinical psychodynamic social work practice. While not all of the subjects in this study were social workers, no difference was found between the responses of clinicians who were social workers and those who were not.

2) The identification with the patient can be a frequent experience in therapy, regardless of the length of time that

the therapist has been in practice. Many therapists suggested that the amount of professional experience that they have has not diminished either the frequency or the intensity of the experience of identifying with patients.

However, nearly all therapists reported that they have become better able both to recognize identification as it is occurring, and to control its influence on their practice and on their lives, as their clinical experience has grown.

Both of these points suggest that the phenomenon probably occurs frequently -- often in an unrecognized and out of control manner -- in beginning social work clinicians. The consequences for their practice would no doubt be the same as those reported by the more advanced clinicians interviewed in this study: more or less serious disruptions of the therapy and the supervision, and potentially stressful spill-over into the therapist's personal life. Increased attention to the this phenomenon in the training and supervision of beginning social work clinicians could have the effect of both reducing the disruptive impact of identifications, and utilizing the benefits of identification to enhance the quality of the treatment.

Recommendations for addressing this issue in the training of beginning clinicians follow logically from the factors that therapists have described as having an impact on their ability to identify with the patient in a controlled and useful manner.

1) Most therapists reported that theoretical understanding of the phenomenon was extremely helpful in recognizing, controlling, and utilizing identifications. This type of theory could be incorporated in masters level social work training in a more systematic way than is currently being done. Practice classes might be good places to incorporate this material. At the present time, discussions of identification -- other than the most general types of warnings about the dangers of overidentification (cf Strean) -- are found in literatures that do not usually form a part of the basic curriculum, and are viewed as appropriate for a more advanced level of study. Given the disruptive potential of this phenomenon, it is might be more helpful to include discussions of identification in more fundamental discussions of the nature of the helping relationship.

Furthermore, the stress that the practice of psychodynamic therapy -- or any similar sort of casework -- can have on the therapist's personal life should also be addressed in the curriculum, and perhaps by advisors as well. Many people find social work training to be emotionally stressful, and the process of identification as it is manifested in beginning therapists who has no understanding of it could certainly be one of the factors in this training-related stress.

2) Similarly, theoretical understanding of identifications could be included in the supervisory process

in a number of different ways. Supervisors could be alert to the similarities between the patient's actions and feelings and the therapist's actions and feelings. They should also be aware of the types of manifestations of identifications that therapists in this study have reported. A few examples include: a therapist expressing undue or exaggerated interest in a particular patient, or a particular problem; a therapist thinking more frequently than might be expected about a patient; a therapist intervening too quickly, or not quickly enough; or a therapist suggesting in an exaggerated way that she understands the patient because the patient is just like her. Supervisors should be particularly alert to the possibility of identifications occurring with paranoid and dissociative patients, as well as any treatment in which the payment of fees has become an issue. Conversely, treatments which appear to be lifeless should be monitored for a lack of identification on the part of the therapist.

Furthermore, supervisors should be alert to possible manifestations of parallel process, which might be signalled by out of character behavior in the therapist. Given the intensity with which identifications can be manifested in supervision, it would also be helpful for agency administrators to be aware of the phenomenon, and to consider it when staff members are behaving in out of character ways.

In order for any of this to be helpful, however, it is important that the supervisor be accepting of therapists

discussing this type of material. The study suggests that therapists find an accepting atmosphere, in which feelings about patients can be freely discussed without fear of judgement, to be most helpful in recognizing and controlling identifications. This accepting attitude would include allowing for discussion of issues in supervision which, superficially, might appear to be personal issues of the therapist which are best left to their own therapy. However, the insidiousness with which identifications can influence therapists suggests that all feelings that a therapist has in relation to a patient could be explored as possible manifestations of identifications. While it might be tempting to limit the exploration to feelings which are interfering with the treatment, the data in the study suggests that it is often not apparent whether feelings are interfering until after an out-of-control intervention has been made.

Specific interventions which therapists have found helpful, such as simply pointing out the similarity with a patient, or interpreting the identification in a non-judgmental way, are possible ways of addressing identification.

3) Therapists should be encouraged, both in university programs and in supervision, to become aware of the personal idiosyncratic areas in which they are vulnerable to developing out of control identifications. Of course, discussion of the need to monitor countertransference has been a part of most

social work programs which have been even marginally psychodynamic in orientation. However, this study suggests that identifications may be more difficult to recognize than other types of countertransference reactions, and may need to be addressed more specifically.

Suggestions for future research

There are a number of aspects of the therapist's identification with the patient which could be of value to explore more thoroughly in future research. Suggestions for qualitative research will be discussed first.

1) An in-depth study of symmetrical identifications -- those in which the therapist and the patient have the same feelings towards each other --would be a particularly important area to study. Such a study would be well justified by the lack of literature on the topic and by the disruptive potential of this type of identification.

2) A more focused study on the effects of identification on the therapist's outside life would also be valuable. The possibility of the therapist carrying the patient's problems over into her own personal life represents a relatively serious danger to the therapist, and one to which little attention has been paid.

3) A more in-depth study of how supervisors can spot identifications, and of the types of supervisory interventions that are most helpful in managing identifications, would be extremely valuable for improving the quality of training.

In light of the present state of knowledge, quantitative methods still do not appear to be a viable research approach to this phenomenon. Although the study suggests that identification is a widespread phenomenon, its manifestations are extremely subtle and multi-faceted, and it remains unclear how the types of variables involved could be quantified in a clinically meaningful manner. While this study did suggest that it was possible to develop an operational definition of identification that allowed various types of identifications to be classified, it is not clear if any of the categories that were developed would be clearly defined enough to serve in a quantitative study.

Furthermore, it is not clear, at this point, whether clinically relevant quantitative hypotheses could be generated at this time. However, it is possible that with further qualitative studies these problems could be reduced, and a quantitative study of the phenomenon could be designed.

APPENDIX B

Interview Guide - Pilot Project

CORE QUESTION: What is the experience like when a psychotherapist is acting, behaving, thinking, feeling, or relating to other people in the same way -- or in clearly similar ways -- as the patient does?

1a) Do you ever find that you are behaving like one of your patients? Feeling? Thinking? Relating to other people?

1b) Can you describe one or more of these experiences in more detail? What form of expression did it take (behavioral? emotional?) How long did it last? What was the intensity?

1c) How did you recognize that it was happening? How did you feel when you realized this? What did you think when you realized this? What did you do with your understanding? Did you act on it in some way? Was it a learning experience? What was your explanation for what happened?

1d) What effect, if any, did the experience have on the treatment. Do you feel that it increased or decreased your empathy for the patient? Do you think that it enhance or diminished your ability to be clear about the direction of the treatment? Do you think that it helped or hampered your work with the patient in any way?

2a) Were you in therapy and/or supervision at the time? Did it show up within the context of the therapy or the supervision?

2b) If so, how? Was it with conscious awareness? Was it re-enacted in a behavioral way, i.e. treating the supervisor or therapist the way the patient treated you? Was your supervisor or therapist aware of what was going on? What type of intervention did they make? Was it helpful? Would a different type of intervention have been more helpful?

3a) Are there any factors related to the work itself which seem to inhibit or facilitate this process. Amount of experience you have (or had)? Type of patient? Phase in treatment? Involvement or disengagement from training and or educational supports.

3b) Were there any personal factors which seemed to be related to the emergence of these moments. Incidents from your own personal history? Phase in your own life?

APPENDIX B

Results of the pilot project

Characteristics of the subjects

Gender: Six of the subjects were female; two of the subjects were male.

Training: Five of the subjects had MSW's. Four had doctorates in psychology (2 clinical PhD's, 1 educational psychology Ph.D., and 1 clinical Psy.D.) One subject had both an MSW and a Ph.D. One subject had a Ph.D. in French literature prior to completing psychoanalytic training, but no other mental health degree or certificate.

Five of the subjects had completed a psychoanalytic psychotherapy training program. Two subjects were currently advanced candidates in psychoanalytic training programs. One subject had extensive psychoanalytically oriented supervision, but no formal post-graduate psychoanalytic training.

Clinical experience: Subjects had between 3 and 22 years of post-graduate/certification clinical experience. They had between 3 and 17 years of post-graduate/certification psychoanalytic supervision.

Personal psychotherapy: Subjects had between 4 and 22 years of personal psychoanalytically oriented psychotherapy.

DATA ANALYSIS

The text of the verbatim notes was analyzed and sorted into general content categories. These general categories were then sorted into sub-categories and sub-sub-categories

based on the various themes, or facets of the phenomenon, that were manifested within the general category.

As this was a pilot study, only one general category was analyzed in detail: the phenomonology of the experience of the therapist's identification with the patient. This category was selected because the actual phenomonology of the experience would appear to provide the most basic data that can be used to understand the nature of the therapist's identification with the patient. Analysis of other general categories -- such as the factors which seem to facilitate or inhibit the development of such identifications, or the therapists' perceptions of the value of the identification, would seem to be dependent on a better understanding of the phenomenology itself. For this reason, the analysis of other general categories will be left for a more complete study.

In selecting a conceptual scheme for describing the phenomenology of the experience, two rather different ways of organizing the material seemed most fruitful. The first was to develop a typology of identifications, based on the characteristics of the experience itself. For example, identifications would have been classified as being conscious or unconscious, or as being acute or chronic. These characteristics of the identifications would have formed the framework of sub-categories and sub-sub categories.

The second way of presenting the material was to utilize the setting in which the identification occurred as the major sub-categorical unit of the analysis. The specific types of identifications which occurred in each setting -- based on characteristics such as whether the identification was conscious or unconscious -- would then be described within the sub-catagory as sub-sub categories.

The choice between these two methods was determined by the goal of the study, which was to provide a description of the range of the phenomenon that would enable practicing clinicians and supervisors to better identify and understand the therapist's identification with the patient as it occurs in actual clinical settings. It was felt that while a topology might be more valuable from a theoretical perspective, a schema that was based on the setting in which the identification occurred would have more clinical utility in terms of helping clinicians and supervisors to identify their own experiences of identification.

Settings in which the identification can occur

The therapist's identification with the patient was seen to be manifested in three major areas of the therapist's functioning:

a) in the treatment sessions, with the patient;

b) in supervisory sessions, with the supervisor;

c) in the therapist's outside life.

Each of these settings will be considered in turn.

identification with the patient in the treatment setting.

The unique characteristic of the treatment setting is that the therapist is in direct contact with the patient, and is thus exposed to the immediate stimulation of the patient's interpersonal functioning.

The literature on empathy (eg., Fliess, 1942; Greenson, 1960; Beres and Arlow, 1974) suggests transient identifications can and should occur in the therapist when she is with the patient, during the session. This type of identification is viewed as being crucial to the therapeutic process.

Nearly all of the therapists interviewed agreed that this occurred, and agreed that it was an essential aspect of the treatment. This type of identification was described as being emotional in nature (i.e. was not manifested either in the therapist's behavior or in his mode of thinking.)

> I see empathy as being a kind of identification. Unless I can enter into a patient's experience, I can't really understand them. I use a transient identification. It's emotional, as opposed to cognitive. (D)

> Without the identification it's all intellectual. You don't really feel what the patient feels. (F)

While most therapists agreed that this process was important, none of the therapists gave detailed examples of a normal, well-controlled transient identification. Most said they were so numerous that they were hard to remember. It is

possible that this phenomenon is so commonplace as to be unremarkable. It is also possible that the interview guide was structured in such a way that it was focused too narrowly on out-of-control examples of identification and did not adequately explore more well controlled examples.

On the other hand, therapists did describe detailed experiences of identifying with the patient in the session which were more or less out of control. There were two broad ways in which identifications could be out of control:

> a) the therapist was conscious that the identification was taking place, but was unable to prevent it from influencing her behavior;
>
> b) the therapist was not conscious that the identification was taking place, and was surprised when she realized what was occurring.

In both kinds of cases, (unlike the well-controled examples that were alluded to, but not described) the identification was usually not limited to a purely emotional experience, but rather was expressed in the therapist's style of thinking or was acted-out in the therapist's behavior.

In cases where the identification was partly or fully conscious, therapists described identifying with the patient's style of communicating to them. Therapists talked in the same way as the patients, used the same kinds of verbal and non-verbal expressions, and generally imitated patient's whole mode of expression. Indeed, the therapist herself appears to

become a reflection of the patient, and the therapy can seem, at these times, to become a folie a deux.

> With some my patients I find that as soon as they come in I start to pick up their mannerisms. I will start talking like them, using the same expressions, or even the same type of physical gestures. It's sort of conscious, but not completely . Not quite involuntary, but not quite deliberate either. I know that I am mirroring them, but I'm not always consciously aware of it, and I am not in complete control of it. (C)

> One of my patients was a cocaine addict. He was very impulsive and hyperactive. He was always joking with me, and [he was] very sarcastic, telling me campy kinds of stories and bantering with me far more than he was actually talking about himself. He wasn't really being a patient. He was coming in and joking around. And I noticed that most of the time, as soon as he came in, I started to joke around too. I often felt that I wasn't really acting like an analyst. That somehow we were just getting together and being witty, telling funny stories. I knew what was happening, that I was acting just like him. But I couldn't stop either one of us.
>
> After about a year and a half he left. When he came back he decided to stop using cocaine, and he started to use his therapy differently. He stopped all of the sarcasm, and I found that I was able to start acting like a therapist again. And now the therapy is doing quite well. (B)

Unlike empathic and transient identifications described in the literature, in which the therapist merely dips into the patient's world temporarily, this type of identification appears to almost force the therapist into adopting the patient's style of communicating. These examples describe how compelling the experience can be; even conscious -- or partly

conscious -- awareness of the process isn't enough to bring it under control. In these situations, it appears to be the patient's dynamics, rather than the therapist's conscious understanding or deliberate interventions, which determine the style of relating in the session. The therapist is like a marionette, with the awareness that her behavior is being manipulated by forces she is unable to fully control.

In other situations, however, the therapist is completely unaware of what is occurring. Or, there may have been an awaress of a general propensity to identify with the patient in a particular way, but this awareness is lost under the pressure of the moment. In either case, the therapist may adopt the patient's world view, feelings, behavior, or thinking. There can be a trance-like quality to these experiences: the therapist functions in an automatic way, suddenly awakening with the realization of what she has been doing. Similarly, the therapist may feel that her actions are motivated by one set of reasons, only to discover later that her behavior has been a carbon copy of the patient's behavior.

> I have one patient who is always in need of a solution to her problems, some sort of an answer. It's as if life and death depended on it. If she doesn't get an answer she gets consumed with anxiety, and it feels like everything will fall apart. Usually I am able to contain it, but sometimes it overwhelms me as well. I begin to feel that if I don't give her an answer to her problem that she will leave me, and that somehow this means that everything is going to fall apart. So I sometimes try to give her answers, but none of them ever seems good and I get very anxious.

> Usually after a few minutes I realize that the world will not fall apart if she doesn't find an answer, and that it is not my responsibility to give it to her. The anxiety abates, and I feel that I have been feeling her feelings with her. I'm always a little surprised. (C)

> I was seeing a child at the clinic. A borderline child. He was known throughout the clinic because he had learned to turn the electricity on and off. He would turn off the lights, and the elevator, and everything.
>
> Once, we moved to a new clinic and he wanted to go around and explore it. There was a new playroom, but not everything in it was new. There were also paints. He said that he wanted to improve everything, and by that he meant to paint. He said he wanted to paint. So I said, "If you want to paint, fine, here is paper, and an easel." But he said no, he wanted to paint the easel. I thought for a minute, and then he convinced me. So he painted the easel, and then he painted the sand box. I had joined with him in the idea that he was improving things. The I got scared because I realized that this was not going to stop. It wasn't an improvement. It was destructive. And I had joined with him. . . When I raised the issue in supervision I saw it just as a technical issue. How can you use the playroom in a way that is liberating, but not destructive? I was really surprised when I realized what I had done. (H)

Both examples describe the feeling of surprise that the therapist experiences when she becomes consciously aware of what has transpired. In contrast with identification described earlier in which the therapist was aware of the process but unable to control it, here the therapist's conscious awareness of the identification does allow her to regain control of her feelings and behavior. However, this self-control emerges only after a period in which the

therapist has been out of control of the identification and out of control of her behavior.

In both of these examples the therapists identified with how the patient was visibly feeling or behaving right in that moment. Another type of identification is that in which the therapist adopts an aspect of the patient's dynamics which the patient was not expressing at the moment but which is an important part of their psyche. This dynamic has been described as the effect of projective identification (Grinberg, 1962;).

Projective identification is a defensive process in which a person rids his consciousness of an impulse or a feeling that he finds intolerable by experiencing it as if it was actually another person's feeling or impulse. (Grinberg, 1962). In the clinical setting this is manifested when the patient experiences one of her own feelings as though it were the therapist's feeling, and then begins to react to the therapist as if this were true. The therapist who is a target of this feeling may then experience this feeling as if it were her own feeling, rather than recognizing that the feeling originally emanated from the patient. This dynamic can, at times, appear to circumvent the therapist's conscious awareness more completely than almost any other type of interaction with patients. And it can have a particularly powerful effect in terms of arousing intense feelings and, at times, flagrant acting-out in the therapist.

> I saw a man once for a consultation. He was very paranoid, and quite bizarre. I felt a lot of fear when I was with him. A lot of fear. All he wanted to do was talk about his sexual and aggressive fantasies about me, and he had never met me before. There was no context for the transference. On the one hand, he was very threatening, but on the other I think that he was very afraid, and that he was giving me the feelings that he was having inside. (F)

> I was working with a borderline patient, and she didn't pay me regularly. We talked about it a lot -- about how she related to people by using them without having to do anything in return.. Paying was always difficult with her, and she left owing a bill. Later she called back, she wanted to come back into treatment. I agreed, but told her that she had to pay her bill first, and also had to pay session by session.
>
> But I still had trouble keeping track of her paying. She'd leave without paying. So I tried a new technique. I ended the session by asking "Do you intend to pay today?." And she would say "Oh yes, I'll pay you next session." So after doing this for a while, the fateful day occurred.
>
> I asked her whether she intended to pay, and she shook her finger at me and said "I've already paid! Its a make-up!"
>
> I realized that I was in the grip of a massive projection. I had become pre-occupied with the money, and had asked for money that wasn't mine. I had become the needy one, and she wasn't. It was a projective identification. She needed to rid herself of greediness and put it into me, and I acted-out on it. (D)

Both of these examples of out of control identifications related to projective identification involved rather clear, intense feelings. However, the same type of process was

manifested in more subtle ways as well, both chronically and episodically.

> I had a patient whose basic problem was that he was trying to make an important decision about what to do about a specific relationship. He had experienced a severe trauma in a similar relationship years earlier, and he wondered whether the earlier trauma could get better, and if he could get another chance at the same type of relationship but with a better outcome than the first time. After we had discussed it extensively, I finally said that some things couldn't be known in advance. You just had to live them out. This was not my characteristic way of talking, but I didn't think anything of it at the time. It helped him to decide to take the risk.
>
> Afterward I got very anxious about it, and I couldn't really figure out why. Then I realized that his underlying problem was a kind of impulsivity in which he felt compelled to live things out rather than consider them and weigh the consequences. In saying that some things couldn't be known in advance, I had identified with this type of impulsive functioning. And the decision that he made did, in fact, turn out to be very bad. (xD)

> There are certain people that I hate. Without reason. I just hate them. Over the years I hypothesize that it is about their hate for themselves. They hate themselves, and they induce that in me. I don't know if that is acting like them, but it is feeling their feelings for them. They are not conscious of hating themselves. With one person, she always worries that people hate her, but she doesn't feel self-hatred. I did hate her, and I wanted to figure out why, Other people didn't hate her, but I did hate her. I think it was her own. (G)

Identification with the patient in the therapist's personal life

The phenomenon of the therapist identifying with the patient outside of the sessions has not been addressed in the literature. However, these therapists in this study revealed that identifications with the patient do take place outside of the session. What is unique about identifications in the therapist's personal life is that they are no longer exposed to the direct stimulation of the of being with the patient, nor are they involved in a relationship which is essentially focused on the patient. Rather, it reflects the extent to which the therapist has internalized the patient.

As with the identifications which occur during the sessions, they span a range of intensity, from being almost completely conscious and only mildly engaging, to being extremely intense and, at times, overwhelming.

Some of the less intense manifestations of the identifications which occur outside of the session have an almost pleasurable quality. They are experiences which are associated with closeness to the patient, with a comfortable level of intimacy. In these cases, the therapists were usually fully aware that what they were feeling was closely related to the patient, and they did not find the experience to be threatening either to themselves, or to their management of the therapy.

> I had a black patient -- one of the first black people whom I had known and treated. She was sick. She had diabetes and heart disease and other things as well. She told me that she was very limited in her diet. The doctors told

her many things not to eat. But she told me that she was never going to give up her southern breakfast. I asked her what that was and she told me eggs, and bacon, and grits with butter. And she ate it every day.

She knows that she is going to die soon, but she doesn't care. Well, I remember that I started to develop a craving for southern breakfast. I had never tasted it. I went away with my family, and we stayed at a hotel, and I found myself ordering a southern breakfast. I had never tasted it, but now I knew what it was. I ate it, and I thought that I was helping her to defy the world. I was helping her to rebel. To go against the rules, the world, against doctors. I did it for her, and with her. A game that she always played was that I didn't understand her because I was not American. But doing this made me feel like I understood her a little better. (H)

There is an art gallery on my street, and part of my routine, for 14 years now, is to look in the window. Then, I got this patient, and about mid-way through our work together I found out that he exhibits in this gallery. Well, I decided then that I couldn't go into the gallery, but that I wasn't going to stop looking in the window. And I would tell him about it if it ever became relevant to the work. Then something interesting happened.

He was in a period when he was enjoying a great deal of success, and he had some stuff in this gallery. I saw it in the window, and I had this fantasy that I would shout out to all of the people passing by "Look! Look what my patient made!". Of course, I'd never do something like that. Then, he came in soon afterward, and he said that as he was watching them hang one of the pieces in the window he had the fantasy of shouting out "Look! Look what I made!" (E).

These types of identifications appear to indicate a high degree of attunement between the therapist and the patient. It is as if the therapist does not simply understand the

patient; her thoughts and feelings actually seem to be synchronized with those of the patient.

Other types of identifications that occur outside the sessions can be more intense -- and far less pleasurable. The feelings can last longer than a few minutes, sometimes going on for days. As with the projective identifications that occur during the sessions, the therapist may have no immediate awareness of the source of the feelings. Or, the therapist may be aware of the similarity with the patients, but this knowledge may not be sufficient to bring the feelings under control. The experience appears to be even more powerful than the types of identifications which occur during the sessions. The therapist appears to have truly woven aspects of the patient's functioning into her own functioning.

The range of feelings with which this can take place is varied. The one theme that runs through all of them is that they are intense and painful. One therapist seemed to have absorbed her patients depression. Another was overwhelmed by her patients panic. This process can be so powerful that it can even lead to a transient psychotic episode in the therapist. The therapist experiences the patient's world in all of its horror, with an almost total eclipse of her own autonomous ego.

> One of my patients is a depressed woman who I have been seeing for two years. We have a good solid bond. Anyway, she gets cyclical depressions. She hadn't had one in a while, but over several weeks I could see that she was starting to go into one of them, and I

suggested that she go see her psychiatrist and talk about adjusting the medication.

Then, I got a message from her that she wasn't coming. Unusually for her, she didn't say anything about re-scheduling. She was very curt. I tried to call her at her session time, but her secretary told me that she was not there. I tried to call her at her home that night, and he husband told me that she wouldn't speak to me.

I fell into a terrible depression that lasted almost two whole days. I felt terribly abandoned. And rejected. I kept asking myself is she was ever going to come back, if she was ever going to call. I did a lot of processing of this, and realized that it was a projective identification. She was putting her depression into me. (F)

One of my patients came in one day and he talked about having a terrible time the night before. He had been on the train, and he began to have a panic attack, and became very paranoid that everybody on the train was after him. He was very suspicious. He began to try to make plans to try to get away, but everything he did sent him deeper and deeper into a panic. He couldn't figure out how he was supposed to get where he was going. He started to change trains trying to get away from people, but the people he was scared of were everywhere. He ended up going into some terrible neighborhood, and was completely terrified.

A few days later I was going to supervision, where I was going to discuss him. The trains weren't working, so I took a taxi. As soon as I got in I became scared that the taxi driver was going to do something terrible to me. I started to try to engage him in conversation, hoping that if I made some human contact with him that he would be less inclined to hurt me. I suggested that he pick up some other customers, so that he wouldn't hurt just me, but then I became scared that they were in on the plot. At one point he took a strange route and I became sure that he was really going to hurt me. It was only later, in supervision, that I realized how this was just like what had happened to my patient. (B)

> This happened with a guy who went crazy. He got fired from his job and being out of work drove him insane. I mean it pushed him over the edge. He was isolated. He didn't have anything else going on for him. And he came into a session and was talking in a very paranoid way. Very paranoid. He really regressed. He got a lot worse than he usually was, from sitting home with nothing to do all day long. And all he's doing is going to the gym and working out. Relating only to himself. It was frightening, even being in the session.
>
> The session ended. I felt normal, but I had a break for a while so I went out to take a walk, and I went to a store to try on bathing suits. When I got in the store I started to feel funny. I started to feel weirder and weirder. And frightened. Like really shaken, to the core. So I started to try on the bathing suits and I got this feeling that I was sure that they had me under surveillance and that there were cameras in the room watching me. I had this horrifying feeling like I was going crazy, that even my thinking was getting crazy.
>
> The thing that was most horrible was that I felt as if my mind was disintegrating and that I was in a nightmare, but that I didn't have control of my mind anymore.
>
> So it wasn't just about being under surveillance, it was a terrifying feeling that my world was collapsing, my psychological world. I though that as I got in the try-on room that some person from the store had simultaneously got into another room where I thought they were in an office watching through a camera. When I came out I was terrified. I went over to one of the sales people and I asked, "Do they have cameras in the try-on rooms?" She was very nice. She said "No, they don't", and I instantly snapped out of it. . . I had been totally contaged by that patient for 45 minutes. (A)

Intense identification reactions which occur outside of the session are not common. None of the therapists who described these reactions could recall more than one or two incidents like this. However, when these types of

identifications do occur clearly have a very powerful, and potentially dangerous, impact on the therapist's personal life.

Identifications in the supervisory setting

Identifications which occurred within the supervisory setting are the manifestations of identification which have been discussed most extensively in the literature. The literature on parallel process is replete with examples of therapists re-enacting aspects of the patient's behavior towards them in relationship to their supervisors.

On the whole, however, the therapists interviewed described fewer examples of identifications occurring in supervision than those that had occurred either with the patient or outside the therapeutic setting. While some therapists were unable to recognize or understand an identification that had occurred with a patient until they had discussed it in supervision, relatively fewer therapists described actually acting or feeling like the patient in relationship to their supervisor.

Nevertheless, experiences of identification did occur within the supervisory setting. Rather surprisingly, however, no therapists described the type of parallel process phenomenon which is most commonly described in the literature, i.e. a relatively brief re-enactment of the patient's behavior by the therapist in relationship to the supervisor which was completely unconscious. Instead, nearly all therapists

reported that they were at least partly conscious of the identification as it was occurring.

As with identifications that occurred either with the patient or in the therapist's outside life, there was a range in the degree of intensity and duration of the process. The least intense types of reactions were relatively brief, and well controlled. The identification is momentary, and the therapist is able to quickly grasp the meaning of the experience and feel it without being overwhelmed by it.

> One patient was always in a rush. He would talk fast, and expect me to solve his problems immediately. I would do the same thing at times with my supervisor. I lay out all of the problems that I was having with him very quickly, and then I would expect the supervisor to solve it for me. I knew what I was doing, but I did it anyway. But this never lasted very long. (B)

> There was one time that my patient was telling me about something that he had wanted with his father and realized that he would never get. And he was very sad, very tearful. I worked with the material and basically didn't feel too much at the time.
>
> When I was talking to my supervisor about it, however, I became really tearful and sad and all filled up with how painful this had been for him. I think that what he was saying had stirred up some feelings in me about stuff with my father, stuff that I had never had and that would never be. All the affect that I had forestalled in the session -- adaptively, in order to do the work -- came back to me in supervision. (E)

However, not all identifications which occurred in supervision were either brief or circumscribed. Indeed, the

therapist's sense that she was feeling or acting towards the supervisor in the same way that her patient was feeling or acting towards her could last for a very long time, sometimes lasting throughout the supervision. As with identifications which occur in other settings, there is the sense that the patient's dynamics have overwhelmed the therapist's autonomy.

> It was a patient that I worked very intensely with, who was extremely monotonous and extremely affectless and did nothing but complain. And then I went to supervision and that's what I would do. I would adopt a kind of depressive monotone and complain the whole time about the person. . . An endless series of complaints in a way that just was incredibly irritating to the listener. And boring, too. That's what I would do. It went on for an extremely long time. I mean years.
>
> I was probably feeling a modicum of what she was feeling. I mean like five per cent, given that she's psychotic and somatizing. . . . And I think that I felt kind of hopeless and helpless, and I know that she felt that way. So in that sense it was similar. It was the same. (A)

> When I was in supervision about George [the patient], I would often feel like George in relationship to D, my supervisor. I would feel like I was crazy. My crazy side was being expressed there. . . With George, my psychotic part identifies with him, and that is threatening. When I talked about George, I would feel crazy with D. I would feel out of control. I'm not as crazy as him, but this was a crazy part of me. I just felt, not paranoid schizophrenia, but more the craziness, the part that is completely out of touch with reality, like there is this wild crazy person. I used to wonder about my supervisor, Does she think that I'm just like him? Is she experiencing me like I experience him?
>
> He was less crazy then. My craziest part and his healthiest part were closer then. .

> . . Those feelings stopped when I stopped presenting him in supervision.
>
> I never really mentioned it to my supervisor, but I felt that she was making me crazy. It was not like I was bringing it in. It was she who was making me crazy. I never thought about it in that direction, but maybe I was making him crazy. He may have felt like I made him crazy. (G)

The chief difference between the identifications that occur in supervisory settings and those that occur with the patient or in the therapist's private life is that in supervision, the therapist is in the presence of the supervisor who is available to observe and explain what is going on to the therapist. In the less intense manifestations of the identification this appears to be effective in helping the therapist to control and understand the process.

> My supervisor just noted what was going on, and that was enough. What else could he do? (E)

> Usually it was enough for the supervisor to point out what was going on and then everything was pretty clear. (B)

However, not enough information was obtained about the longer lasting identifications to determine how effective supervisory interventions may have been in controlling them. In one case, the supervisory interventions were perceived as being helpful to the therapist, but did not completely control the situation. And in another case, the therapist did not trust the supervisor sufficiently to discuss the situation,

so it is not known how effective the interventions may have been. Neither situation, however, can be said to represent a trend in the material.

One therapist had a comment about how he experienced the phenomenon of identification in supervision which differed from the rest of the therapists.

> Sometimes I have been told in supervisory groups that I am feeling or expressing the patient's anxiety. However, I don't think that really was the case. I think there were enough reasons to feel anxious just in the context of the group to explain my anxiety without bringing the patient into it. (C)

This idea was only reported by this one therapist, and, as such, cannot be said to be representative of a theme in the material. Nevertheless, it is an important comment, for it suggests that identifications may be perceived by the supervisor that are not experienced by the therapist herself. This suggests the possibility that a therapist can be unaware of an identification even after it is pointed out to her, or that the supervisor is misinterpreting what is going on. In the latter case, it is possible that the supervisor might have a theoretical bias towards viewing material in this way, even when it is not the case. This would be an important area to explore in subsequent research, with a larger sample size.

Summary

While all therapists agreed that identifications with the patient in the session were an integral element in

psychotherapy, none described detailed accounts of an ordinary, well-controlled type of identification. What they described instead were a wide variety of experiences of identification which were to a greater or lesser extent out of their conscious control. Most of these out-of-control identifications resulted in some sort of acting-out on the part of the therapist.

Sometimes the therapist was conscious that the identification was taking place, but was still unable to control the behavior. These types of identifications usually took the form of adopting the patient's style of communicating or relating to the patient. At other times the identification took the form of the therapist unconsciously colluding with the patient's acting-out. This acting-out stopped when the therapist became conscious of what was taking place.

In many instances, the therapist identified with the feelings and/or behavior of the patient which were immediately apparent to the therapist. At other times, however, the therapist felt or acted out feelings of the patient which were not immediately apparent. These feelings were split off from the patient through the defensive process of identification. These types of identifications could be quite dramatic, involving what was in retrospect clear acting-out on the feelings by the therapist. Or they could involve more subtle expressions that were either acted-out, or remained confined to the therapist's emotions.

On the whole, there was somewhat less variety in the identifications which were manifested outside of the session than those that were manifested inside the session. Some of these experiences were relatively circumscribed episodes which were conscious or partly conscious. These were often associated with a pleasurable feeling of intimacy or attunement with the patient. On the other hand, therapists also described painful unconscious identifications which were the most powerful and potentially dangerous types of identifications that therapists experienced in any setting. Although these latter reactions were infrequent and transitory, the had an extremely disruptive effect on the therapist while they were operating.

Identifications in the supervisory setting appeared to be less ubiquitous than the literature on the phenomenon suggests. Some examples of identifications within supervision involved brief, circumscribed conscious episodes of talking or acting like the patient. Others involved more powerful identifications in which the therapist consistently felt like the patient in relationship to the supervisor for extended periods of time. In all cases the identifications were described as being wholly or partly conscious, in contrast with the vast majority of the examples that have been presented in the literature on parallel process.

Discussion

Overall, the analysis of the data suggests that the therapist's identification with the patient is a complex phenomenon that can be manifested in a wide variety of ways in many areas of the therapist's functioning.

Although there were numerous areas of similarities between various types of identifications which occurred in different settings, two characteristics of the phenomenon in general were of particular clinical relevance.

First, most of the identifications that were described by therapists (with the exception of some of the mild identifications that therapists experience in their personal lives) involved negative, painful, or disturbing feelings. By and large, therapists did not report intense or out of control identifications with patient's pleasurable feelings, or with successful, competent areas of the patient's personality. Rather, it was the patient's problems (or problematic areas in the patient's personality) that therapists identify with. This would be any important area to explore in with a larger sample, as this understanding could be helpful in allowing therapists to identify these episodes more quickly.

Second, the experience of identifying with a patient can be extremely difficult to both detect and control. Certain types of identifications in all settings were characterized by the fact that the therapist was completely unconscious of the identification as it was occurring. Such unconscious

identifications frequently led the therapist to act-out or re-enact aspects of the patient's behavior. These identifications were nearly always identified after they had occured.

In many cases, the therapist's conscious awareness of what was occurring was sufficient to allow her to regain control of the situation. In other cases, however, the therapist's conscious awareness was *not* sufficient to allow her to regain control; the process was more powerful than the therapist's conscious understanding.

Thus, the identification with the patient is an experience that can cause the therapist to lose control of her behavior. Although therapists' ideas about the effects of this phenomenon on the therapeutic process were not analyzed in this study, it is clear that this is an area that needs further exploration. Any experience that can cause the therapist to function in an out-of-control manner towards the patient poses a potential threat to the success of the therapy.

Similarly, the analysis of the data also suggests that the identification with the patient can have an impact on the supervisory process. The data suggests that it would be particularly important for supervisors to be alert the phenomenon, as a therapist in the throes of an out-of-control identification might behave in ways that would be utterly inexplicable if the supervisor did not understand what was

occurring. Such a situation could create a formidable obstacle to the success of the supervision.

Finally, the analysis of the data suggests that the identification with the patient can have an extremely disruptive effect on the therapist's personal life. Although none of the examples of out-of-control identifications described in the study led to any lasting damage in the therapist, they were nevertheless extremely stressful for the therapists involved. Again, an understanding of this phenomenon and alertness to these kinds of experience on the part of the therapist would appear to be crucial to minimizing the stress involved in the practice of psychotherapy.

A larger study, with a broader analysis, is necessary to further clarify both the phenomenology of the experience itself, and to obtain information about other themes which are related to the experience.

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