The Fear of Compassion*

A misreading of Freud has perpetuated two compelling and ubiquitous shibboleths, the fear of countertransference and the abstinence rule, that deprive psychoanalysts of the privilege of having the use of all of their feelings, especially the feeling of compassion and of behaving compassionately with their patients. The author attributes this state of affairs to reaction formation and to the development of a countertransference resistance. In effect Freud's advice about resistance has been transposed into a resistance (i.e., against feeling) itself.

This brief presentation might well have been titled, "On being human, though a psychoanalyst," for in it I intend to discuss psychoanalysts' reluctance to meet with simple human feelings the suffering they witness in their patients, irrespective of the source of such misery. I attribute this state of affairs to what psychoanalysts call reaction formation, and to the development in them of a countertransference *resistance* to feeling compassion.

Human compassion is, I believe, an emotion singularly human and singularly civilized, and probably the last, or at least among the last emotions to have evolved during the long phylogenesis of the human psyche. Tradition has it that compassion is almost "god-like," forming no small part of modern man's religious heritage. ("To err is human. To forgive is divine.") Only lately and after much suffering and resistance has pitilessness in human relations begun to yield to pity and compassion, but even a casual review of the extensive cruelties that still characterize human behavior confirms that the evolution of compassion in the human species is still far from complete.

Like humankind in its beginnings, human beings are still born without the capacity to experience the feeling of compassion. They acquire

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this ability, if at all, as a result of a socialization process, which renders them into mature adult persons. For better or for worse, in one sense or another, psychological *ontogenesis* (development of individual personality) often recapitulates cultural *phylogenesis* (evolution of a cultural group). Neither animals nor children are truly compassionate. Indeed, compassion seems to be among the attributes that mark a person as being capable of mature love. Compassion bears a relation to the affectionate component of love analogous to the relation that genitality bears to the sensual component. Infantile love is neither compassionate nor genital. Parental love, on the contrary, requires both of these components to be present. It would not be stretching the point too far to suggest that transference love in a patient is comparable to the former, and countertransference love in a psychoanalyst is comparable to the latter.

A naive and literal misreading of Freud has perpetuated two ubiquitous and compelling psychoanalytic shibboleths, both of which conspire to deprive psychoanalysts of the privilege of enjoying their feelings, especially the feeling of compassion, and of the option of behaving compassionately with respect to their patients. These shibboleths are the fear of "countertransference" and the "abstinence rule." I am inclined to attribute many treatment failures to the prohibition against compassionate behavior on the part of psychoanalysts that misapplication of these two dogmas has led to. In support of this contention I shall later report my first and most dramatic treatment failure. I credit this failure to my inability or unwillingness to act compassionately toward a patient. This inability was a result of my previous indoctrination regarding the handling of countertransference and the implementation of the abstinence rule. I shall also report an equally dramatic success that followed when I threw off my inhibitions in these matters and acted as a compassionate human being.

Although Freud (1910) makes only a passing reference to "the countertransference" as a problem in psychoanalysis, his brief comment on this issue has had a persisting and pervasive influence on psychoanalytic practice, supervision, and training. The countertransference, Freud says, "arises in the physician as a result of the patient's influence on his unconscious feelings" (p. 144). He recommends that a psychoanalyst "recognize and overcome this countertransference in himself." For a psychoanalyst's "achievement is limited by what his own complexes and resistances permit." Accordingly he should practice self-analysis and "should extend and deepen this constantly while making his observations on his patients. Anyone who cannot succeed

in this self-analysis may without more ado regard himself as unable to treat neurotics by analysis'' (p. 145).

The nub of these remarks is that psychoanalysts should not be victimized by their own complexes and resistances but should be constantly on the alert through self-monitoring against ''unconscious feelings'' that might interfere with their freedom to conduct a successful analysis. The crux of the matter is not the psychoanalyst's feelings but the psychoanalyst's resistances. It is a travesty that this interdiction *against resistance* has itself been transposed *into a resistance* against feelings. For it is precisely a psychoanalyst's resistance to recognizing his own feelings that Freud identifies as the countertransference problem. The clearest evidence of countertransference resistance is an inability or unwillingness on the part of a psychoanalyst to experience normal and appropriate feelings when these are called for and when these might usefully serve a patient and advance an analysis.

It appears to me to be necessary to discriminate between unresolved transferences in a psychoanalyst, countertransference feelings, and what might more properly be called countertransference resistances. It is not a new thought, I am setting forth here, that countertransference feelings need not constitute an impediment to psychoanalysts but may in fact be utilized by them as a powerful source of analytic material with which to further treatment.

However, it is my contention that if an analyst is a normal, mature human being, his or her human response to the perception of a need for help on the part of another suffering human being might legitimately be a feeling of compassion. And yes, even an *act* of compassion may serve a *therapeutic* function, though not necessarily a purely *analytic* one!

Compassion is the socially complementary role response to a child or to a person in need of help or to any living creature in pain. A patient's expressed or implied *transference* need, ''Help me!'' might ordinarily be expected to induce a feeling of compassion in an analyst. Unfortunately, a misreading of the countertransference prohibition makes analysts, or at least young analysts and beginning analysts, afraid of having any feelings. Instead of responding to a patient's demand for help by feeling compassion, analysts all too frequently renounce such normal feelings in favor of a countertransference resistance. Thus, instead of feeling compassion in the face of a patient's entreaty to ''Help me!'' they feel coldness, objectivity, and withdrawal. Under the circumstances the presence or absence of compassion in each instance is surely a countertransference that must be rigorously analyzed for both its objective and subjective components.

The fear of countertransference feelings derives powerful sustenance from still another source. In 1912, Freud advised: "I cannot recommend my colleagues emphatically enough to take as a model in psychoanalytic treatment the surgeon who puts aside all his own feelings, including that of human sympathy, and concentrates his mind on one single purpose, that of performing the operation as skillfully as possible" (p. 115).

Such an unequivocal and emphatic declaration hardly seems to lend itself to any but the literal interpretation that psychoanalysts have placed upon it—namely to eschew all feelings during the conduct of treatment. But to more fully appreciate Freud's advice on this matter requires a thoughtful appraisal of the reasons he sets forth for his conclusion. It is not the psychoanalyst's compassionate impulses that Freud elects to indict, but he says, "the affective impulse of greatest danger will be the therapeutic ambition to achieve . . . something." Moreover, Freud explains, "The justification for this coldness in feeling in the analyst is that it is the condition which brings the greatest advantage to both persons involved, ensuring a needful protection for the physician's emotional life and the greatest measure of aid for the patient" (p. 115).

It is clear from these remarks that Freud is concerned about the interests of both members of the psychotherapeutic dyad. This coldness of feeling, he says, provides a needful protection for the analyst's emotional life, and at the same time protects the patient from any misplaced aspirations or abuse under the guise of "therapy." Freud accordingly recommends that psychoanalysts put aside all of their own feelings and concentrate on one single purpose, that of performing the analysis as skillfully as possible. Like a surgeon, psychoanalysts are obligated to undertake all procedures that advance treatment, notwithstanding their own feelings and prejudices and their own self-interest. They must refrain from exploiting patients to attain theoretical, research, or personal objectives. In this connection it is of interest to note that *overcommitment* to any theoretical position limits a psychoanalyst's effectiveness as a therapist and constitutes one of the more frequent and more pernicious sources of unanalyzed countertransference resistances.

Ideally, mature normal adults are persons who have stopped acting as though they expected others (except perhaps those who love them) to be absorbed with their personal problems or their state of well being, and instead have assumed the primary responsibility for their own protection and gratification. They have discarded unrealistic expectations that the world or other people will act toward them as benevolent

parents, and have shifted from an ego-centered view to a more objective view of themselves and the world. They are thus able to put their own wishes into perspective with reality and to minimize projective distortions arising from wishful thinking. Their mature egos enable them to tolerate the frustration of knowing that they cannot always have what they want but must renounce gratifications that are unattainable.

Emotionally immature individuals cling tenaciously to the ungratified wishes of their infancy and refuse to surrender these even in the face of clear evidence that wish-fulfillment has long since become a virtual impossibility. It is easy to see that such persons will continue both in analysis and outside of it, to seek parental surrogates upon whom they will endeavor to transfer the responsibility for their personal care and happiness.

Even the mightiest are not immune from wishful thinking when the need is great enough. It will be remembered that Freud had a marked propensity to develop transference attachments and did so to a succession of heroes, among whom can be numbered Brucke (''the greatest authority I ever met''), Helmholtz (''he is one of my idols''), Meynert (''in whose footsteps I followed with such veneration''), Breuer (''he radiates light and warmth''), and later Fliess, Jung, Ferenczi, and a host of others. These attachments were usually terminated by an emotional crisis that was soon followed by a kind of reaction formation. But while the positive transference continued it was difficult for Freud to evaluate the creative productions of these men realistically. His relation to his close friend Wilhelm Fliess is the most notable instance of this weakness (Jones, 1953).

Psychoanalysts since Freud have continued to develop, on account of their didactic personal analyses, transferences to their teachers. And many have in addition developed transferences to Freud and many of the other distinguished members of the profession. Just as Freud ''idolized'' Helmholtz from his reputation and writings alone, just so do many psychoanalysts ''idolize'' Freud, Jung, Adler, and others. These transferences are all the more insidious because they are unconscious and go unnoticed by the psychoanalysts who fall victim to them. This denies them an opportunity either to modify and resolve these transferences or to become aware of the effect they have upon their theoretical outlook and therapeutic approach. It is often difficult to distinguish between neurotic adhesiveness on the one hand and a rational preference for and adherence to a particular psychoanalytic school of theory and practice on the other. Freud (1913) observed: ''Whoever is familiar with the nature of neurosis will not be astonished to hear

that even a man who is very well able to carry out analysis upon others can behave like any other mortal and be capable of producing violent resistances as soon as he himself becomes the object of analytic investigation'' (p. 346).

Many psychoanalysts may well wish to deny that unresolved transferences to their training analysts or to renowned figures in the field persist among the graduates of well-conducted training analyses. This may be so. But the perfect analysis is an ideal that is hardly ever realized, if it is possible at all. In fact, as we shall endeavor to show, the idea of a perfect analysis is a chimera arising from the unresolved transference itself. Weigert (1952) writes, ''like Ferenczi, I can not count many completed analyses in a practice of some twenty years'' (p. 467).

Though few analysts lay claim to perfection, still they shy from the knowledge of their own imperfections. To those who can survive such narcissistic injury, the awareness of shortcomings in their heroes, as well as the consciousness of personal shortcomings, may enable them to surrender what little comfort derives from the illusion of omnipotence in exchange for the benefit of a more objective appraisal of their abilities. We remain indebted to Ernest Jones (1953) for his careful biography of Freud, for he succeeds in making this ''god'' mortal without in any way detracting from his genius, thus releasing us forever from thralldom and the worship of this great man.

While it has become fairly easy for psychoanalysts to forego whatever ego satisfaction there is to be derived from the uncritical overestimation of themselves by patients in the throes of transference love, they have not been so ready to renounce the narcissistic rewards they derive from the praise and respect of their colleagues. This is one of the reasons, I think, why some analysts feel compelled to cloak their work and procedures in secrecy and shy from publication. Summing up his years of observation, Martin (1956) concluded that the responses advanced by his colleagues as the reason for not making scientific contributions ''served the purpose of hiding the fact that they were afraid of unfavorable criticism. To make it a requirement that one first acquire the 'omniscience' of the elders before taking the risk of expressing his own ideas is to put it succinctly to be at the mercy of an underlying castration anxiety'' (p. 416).

Until recently papers on countertransference, treatment failures, and errors which exposed the analyst as a person have been relatively rare. For instance, from 1952 to 1957 only four out of 135 articles that appeared in the *Psychoanalytic Quarterly* dealt with countertransference. Analysts have been exceedingly loath to be frank and explicit

about what actually goes on during their treatment hours, often acting as if they were sacrosanct. This attitude has contributed more than a little to the failure of treatment techniques to keep pace with our growing understanding of human behavior. Only cross-validation, critical evaluation, and interdisciplinary cross-fertilization (virtually impossible under conditions of secrecy) can save analytic technique from stagnating into an empty ritual.

"You know that we have never been proud of the fullness and finality of our knowledge and capacity; as at the beginning, we are ready now to admit the incompleteness of our understanding, to learn new things and to alter our methods in any way that yields better results" (p. 392), Freud wrote in 1919.

So what accounts for the unwillingness or inability on the part of analysts to be experimental or to report the results of departures from the well known and the well-worn paths of orthodox psychoanalytic procedure? What prevents analysts from embarking upon independent research and innovation in their techniques and in their ways of looking at things? Moreover, what accounts for the resistance and hostility on the part of many analysts when such innovations are suggested or reported? Psychoanalytic theory and practice are surely still far from perfected.

These questions find a ready-made answer. Psychoanalysts who exhibit such attitudes of opposition to experiment are behaving precisely as neurotics behave. A neurosis, after all, is a compulsive form of repetition of a pattern of behavior learned in the past but which is not modified to meet the demands of the present situation. This particular form of neurosis is a peculiar one, however. It seems somehow related to psychoanalysts' own didactic analysis and it seems to consist, in the main, of a compulsive repetition of their experience with their own analysts. Just as patients in transference recreate their own oedipal relationship with their analysts, just so may analysts recreate their own analysis with their patients. They do with their patients what their own analysts did with them. Or, they may do with their patients what they *desired* their own analyst to do with them. There is, of course, no necessary harm in this when it is done consciously, because identification with a patient sometimes advances an analysis. But overidentification with a patient signifies that one suffers from an unresolved transference neurosis related to one's own analysis. Just as a healthy, mature adult ceases to overidentify with children and ceases to feel weaker than and dependent on his parents, a mature analyst ceases to overidentify with patients and feels independent of and equal to his or her own analyst.

Weigert (1952) observed that "the resistances of transference disappear toward the end of a successful analysis and that a greater spontaneity between analyst and analysand is established. The spontaneity of the analysand is only possible if he no longer feels compelled to please, to placate, to test, or to provoke the analyst" (p. 467). The analysand must be able to relate to the analyst as another adult and must become capable of thinking for himself or herself. As long as analysts look with awe upon their own analysts, not having been able to establish a real relationship to them, they have failed to resolve the transference and this circumstance will eventuate in neurotic manifestations.

Besides the misinterpreted dictum about countertransference, no other idea about technique has suffered more distortion and abuse than the so-called abstinence rule that Freud described in his 1919 paper. "*Analytical treatment should be carried through, as far as it is possible, under privation—in a state of abstinence*" (p. 396; italics in original). This has been taken to mean, in spite of Freud's explicit instruction to the contrary, that patients should be deprived of every form of gratification both in and outside of treatment. But again a more careful reading of Freud shows that this is far from the case. "By abstinence, however, is not to be understood doing without any and every satisfaction," Freud says, "nor do we mean what it popularly connotes, refraining from sexual intercourse. . . . A certain amount must of course be permitted to him, more or less according to the nature of the case and the patient's individuality" (p. 396).

Nevertheless, analysts have all too frequently used the notion that frustration is good for patients as a rationalization for abstaining from decent and compassionate behavior when such actions could be entirely justified. After all, except for training analyses, the ultimate goal of treatment is cure not merely insight. The issues that must bear the most intensive scrutiny are when and under what conditions is gratification of a patient's needs therapeutically indicated and when and with respect to what kind of needs would gratification merely cosset the patient's neurosis. On these issues Freud is crystal clear. The analyst, Freud says, must energetically oppose the satisfaction of *substitutive* or neurotic needs. An analyst, out of the fullness of his or her heart and readiness to help, should not extend to a patient *all* of the help that one human being may wish to receive from another. It is not good to extend too much help. Nor should one make things too pleasant for patients so that they find satisfactions in the treatment that might better be found elsewhere. The goal of treatment is to make a patient stronger and more able to carry out the actual tasks of living.

Thus the treatment should not be allowed to become a substitute for facing life.

These mandates cannot and should not be construed to mean that under no circumstances should analysts permit themselves to make things pleasant or to meet a patient's needs. In fact, quite the contrary is often the case, especially with very young or very helpless patients. Such patients, by virtue of their infantile and dependent state of development, bring us a whole array of *maturational* needs that are our obligation to fulfill. Indeed, one of the major technical goals of treatment is gratification of maturational needs, for failure to gratify such needs inhibits the process of maturation and growth. One has to be extremely careful not to throw the baby out with the dirty bath water. Both frustration (of substitutive needs) and gratification (of maturational needs) are required. Gratification of maturational needs prepares a patient to be able to renounce substitutive gratifications.

To give force to these suggestions, I shall briefly recount my behavior with respect to two patients, Jane and Mary, both of whom can be described as extremely infantile dependent women, each of whom had at one time or another been hospitalized with acute episodes. It is not my intention to suggest that the two cases are necessarily diagnostically comparable but merely to examine the differences in my own attitude and behavior as an analyst. In Jane's case I believe I acted as a normal compassionate human being and in Mary's I did not. I treated Mary in an earlier stage of my development, Jane more recently. In both cases the patients developed typically intense erotic narcissistic transference attachments to me. As parents do for babies, I became for them the source of hope, love, and survival. For Mary, I was unfortunately still unprepared by temperament and training to enact this role; with Jane (perhaps thanks in part to my experience with Mary) I willingly assumed these responsibilities. The differences in the outcomes were equally dramatic.

When Mary came to me many years ago and detailed the dreadful history of her life and problems I did not feel any less compassion for her than I did when I became Jane's therapist 15 years later. My trouble with Mary was that I was still encumbered by my fear of countertransference reactions and by my belief in the validity of the abstinence rule. So when this unhappy and deluded young woman became financially destitute because her acute and crippling emotional state made it impossible for her to function and to support herself and to continue to pay her analytic fees, I felt obliged (against my own compassionate wishes) after many months of her failures to pay her fees, to discharge her from treatment, with the proviso that she return

after she could pay her fees. My rationale was that I would be pandering to her dependency and to her "unrealistic" expectations if I allowed her to continue in treatment any longer without having to pay. The very next morning I was informed that Mary had suffered an acute psychotic episode and had been hospitalized. She had run up onto the stage in the middle of a theatrical performance, interrupting the show and begging the leading man to "Help me!"

No one can rewrite history, and perhaps it is idle to speculate on what the outcome might have been had I acted as a compassionate human being might have done in similar circumstances and waived the fee. But my intuition tells me that had I done so, things might have ended differently for Mary.

I cannot use the case of Jane to prove this contention because the circumstances and the personalities of the two women are so different. But I would like to report what Jane said to me to substantiate the proposition that simple compassionate behavior can sometimes alter the course of events when a patient is in acute need. Jane was a clinic outpatient whom I was treating at a city hospital. When I heard that Jane had been picked up and brought to the hospital in a fugue state (due to overmedication and alcohol) and was lying alone in the psychiatric ward, I visited her there. I did this because I felt compassion for her and because I knew that besides me the only creature that she cared about was her dog, who might still be locked up and unattended in her apartment. I was worried about the dog and I knew that she would be also. Jane was indeed alone and half-conscious in her bed when I entered the ward. The gratitude in her eyes was quite moving to me as I bent over to exchange a few reassuring remarks with her and told her that I would see to it that the hospital social work department would visit her apartment to provide for "Trixie."

Jane was eventually transferred to a medical ward and hovered close to death for many weeks. She slowly recovered her strength, though she remained partially paralyzed for a while, regaining the use of her arm by sheer hard work and will. The road back to physical and mental health (she will never fully attain either) took about a year but was quite notable. One day, quite spontaneously, she turned to me and remarked, "I have been meaning to tell you something for a long time. You know, you saved my life. I had lost hope and I didn't want to live any more that day in the hospital. But I opened my eyes and I saw your face. You were smiling and I knew you cared about me and that things weren't so bad. Thank you."

Appeal to authority for the justification of any procedure is anathema to science. Resistance to modifications in technique in the face

of therapeutic failures is equally irrational. Unless analysts determine to be, as all scientists must, disinterested, objective and concerned about ascertaining the nature of reality rather than to be ruled by faith in their masters and the necessity to live up to tyrannical superego ideals, psychoanalysis and psychoanalytic treatment will become a sterile ritual enjoyed neither by the priests nor the acolytes.

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