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A History of Contempt: Countertransference and the Dangers of Service Integration

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Introduction

One of the most significant contributions psychoanalysis made to the development of human service interventions was the elucidation of the twin complexities of the helping relationship. The concept of *transference* suggested that client's experiences in their most significant prior relationships were projected into their relationship with the professional helper. The concept of *countertransference* suggested that the professional helper's past relationships and feelings were similarly elicited and projected in unique ways onto each client. In psychoanalytic thinking, the manner in which these transferences and countertransferences went unseen or were actively managed was thought to dictate the outcome, good or bad, of the helping process.

Countertransference is the "total emotional reaction of the therapist to the patient"–a reaction that involves the therapist's beliefs about the client, his or her feelings for the client, and his or her overall attitude toward the client (Imhof, 1991). Countertransference is composed of both collective sentiments (those based on categorical responses to such issues as race, gender, age, sexual orientation, and problem type) and idiosyncratic sentiments (those based on unique emotional reactions of the therapist to a particular client). This article will 1) review the history of a particular type of countertransference that has often marred the relationship between professional helpers and those addicted to alcohol and other drugs, 2) describe the unique antidote that mutual aid societies and addiction counselors brought to that problem, and 3) raise concerns about the intensification of countertransference problems amidst the current wave of service integration initiatives.

Addiction and the Therapeutic Encounter

Addiction to alcohol and other drugs is often wrapped within an elaborate defense structure created in response to the loss of control over alcohol or drug use,

the social stigma attached to addiction, and the heightened vulnerability of the therapeutic encounter. Over time, this primitive defense structure is exaggerated and frozen into a self-fulfilling view of self and the world. It is not surprising then that addicts develop chronic self-defeating styles of interacting with professional helpers via passivity (superficial charm, temporary compliance, flight into health, social withdrawal) or aggression (justifying, blaming, acting out, intimidating, fleeing)(White, 1996).

Professional helpers bring their own emotional responses to addicts and their defensive gambits. Cohen, White and Schoolar (1971) ask, "How does one move unflinchingly into an arena where he or she is made to feel unwanted, incompetent and even malevolent?" The historical answer to this question is that helping professionals have avoided such discomfort by excluding addicts from various service contexts or by becoming over-involved, engulfed and embittered in such encounters. It is at these extremes that professional helpers have been guilty of ethical breaches that range from clinical abandonment (disrespect, emotional detachment, avoidance, and service extrusion) to enmeshment (rescuing, emotional fusion, intimacy violations).

Cycles of Contempt and Respect

While professional countertransference can stem from highly personal sources, it can also flow from larger cultural attitudes toward those addicted to alcohol and other drugs. Views toward persons with severe alcohol and other drug problems have vacillated among the public and among helping professionals. There are eras in which addicted persons are defined as morally inferior (dangerous "fiends") and subjected to systems of sequestration and punishment. These eras create the stigmatized soil out of which recovery mutual aid societies and specialized addiction treatment institutions are spawned. There are also eras in which persons addicted to alcohol and other drugs are viewed as our family members, friends, neighbors and co-workers–people viewed as morally worthy of our compassion and care. As attitudes toward addiction soften, the care of addicts evolves through the creation of specialized institutions to their integration into more mainstream service systems. These cycles of categorical segregation and integration define the types of institutions in which addicts find themselves, and they shape the attitudes of the staff they encounter within those institutions. Such cycles can be illustrated through a few snippets of history.

In 1833, social and professional attitudes toward the alcoholic were described as follows: "they repulse the drunkard from their doors; neglect his

sufferings; and whenever they meet him, manifest their contempt and abhorrence of him" (Sigorney and Smith, 1833, p 38). In the face of such attitudes, it is not surprising that alcoholics were perceived as morally unworthy to receive care in hospitals and psychiatric asylums. The Washingtonian revival of the 1840s created a sanctuary for the stigmatized alcoholic: "The drunkard is now regarded in a new light....Instead of being considered a cruel monster–a loathsome brute–an object of ridicule, contempt and indignation, as formerly, we are now taught to look upon him as a brother...as a slave to appetite, and debased by passion–yet still as a *man, our own brother*" (A Member, 1842, p. 65). The Washingtonians brought, in addition to a technology of recovery initiation (the public pledge, mutual surveillance, and service to others), a new attitude of regard and respect for the alcoholic. The inebriate homes and asylums of the nineteenth century were similarly birthed out of the belief that only in a specialized institution could the inebriate find the respect and care essential for his or her full recovery.

In the early 1870s, two recovering alcoholics, Jerry McAuley and his wife Marie, founded the Water Street Mission in New York City, marking the formal beginning of faith-based recovery ministries. One of McAuley's biographers described the Mission as a place where "men and women burdened with sin, broken down and shattered by debauchery and vice, homeless and hopeless, hungry, ragged and defiled, drunk or sober, fresh from prison or the gutter, are welcomed, are made to feel that somebody cares for them and theat their wretched past has not made decency and respectability in this life and salvation in the life after impossible to them...." (Offord, 1885, p. 176-177). The rescue missions were a reaction to the climate of social contempt and the failure of mainstream religious institutions and the larger community to reach out to the suffering alcoholic and addict.

When the nineteenth century network of inebriate homes and asylums collapsed in a wave of therapeutic pessimism that culturally redefined addiction in moral terms, alcoholics and addicts were sheparded into inebriate penal colonies, the back wards of aging state psychiatric hospitals, or in expensive, but discreet, private drying out facilities. Two stories illustrate the unwelcome reception they encountered in these institutions.

Marle Woodson was legally committed to Eastern Oklahoma Hospital, a state psychiatric asylum, in 1931 after having spent thousands of dollars on treatment in private psychiatric institutions. When the physician assigned to treat him first entered his room, Woodson extended his hand to shake hands with the doctor. Woodson describes what happened: "The look which the doctor gave me simply set me back on my heels. My hand remained untaken...Then I realized with

a shock that this was not a meeting of two gentlemen on a plane of equality. In the eyes of the man before me, I was just another insane patient" (Woodson, 1932, p. 7).

The noted American author Willie Seabrook was admitted to Bloomingdale Asylum for the Insane for treatment of alcoholism in 1933. Seabrook's psychiatrist, reflecting the attitudes of many professional helpers toward alcoholics during this time, complained to Seabrook, "every time we've taken a drunk in this place, we've regretted it." (Seabrook, 1935). Such professional contempt was the norm in this era of non-specialized treatment.

The "modern alcoholism movement" (Alcoholics Anonymous, the Research Council on Problems of Alcohol, Yale Center of Alcohol Studies and the National Committee for Education on Alcoholism) rose out of the soil of such stigma. Why did the pioneers within these institutions champion a segregated system of care for the addicted? Because they had come to believe that alcoholics and addicts could never be helped in mainstream institutions permeated with such attitudes. As a result, alcoholics found entrance into new hospital-based alcoholism units cared for by people like Sister Ignatia (know as the "Angel of Alcoholics Anonymous") and Dr. William Silkworth (known as the "little doctor who loved drunks"). Their achievements were more attitudinal than technical. Marty Mann, a central figure in the modern alcoholism movement, declared that the key to successful treatment "is accepting the other person just as he is, for exactly what he is....it accords him the dignity of his humanity quite apart from his illness which may have buried that humanity deep out of sight." (Mann, In Staub and Kent, 1973, p. 3)

The field of addiction treatment emerged as a segregated field of professional service in the 1970s because the lay and professional leaders of that field were convinced by their study of history and their own collective experiences that alcoholics and addicts would not be welcomed nor would they ever get the care they needed within mainstream mental health, public health and social service agencies. The majority of those who birthed this specialty field knew from their own personal experience just how inept mainstream institutions were at treating the alcoholic/addict and that the best interests of alcoholics/addicts were unlikely to be served in such institutions. They also knew that this was a failure both of technology (misguided assumptions and ineffective methods of intervention) and of attitudes. Those understandings became the impetus for a re-birthed field of addiction treatment and new specialty roles in addiction medicine and addiction counseling. While there have been many technical breakthroughs in the specialized arena of addiction treatment, what these new roles most contributed

was a revival of respect for those impacted by addiction and a willingness to enter into service relationships characterized by authentic emotional contact and mutual vulnerability.

Countertransference and Service Integration

The restigmatization, demedicalization and recriminalization of the past two decades threatens to end the era of revived respect in which most of us have pursued the profession of addiction counseling. Alcoholics and addicts are being moved in large numbers from systems of care to systems of control and punishment. Addiction treatment programs are facing a wave of service integration initiatives that threaten their character and their future. Four things have allowed addiction treatment practitioners to shun the cultural contempt with which alcoholics and addicts have long been held: 1) personal experiences of recovery and/or relationships with people in sustained recovery, 2) addiction-specific professional education, 3) the capacity to enter into relationships with alcoholics and addicts from a position of moral equality and emotional authenticity (willingness to experience a "kinship of common suffering" regardless of recovery status), and 4) clinical supervision by those possessing specialized knowledge about addiction, treatment and recovery processes. We must make sure that these qualities and conditions are not lost in the rush to integrate addiction treatment and other service systems.

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