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"Impatience of the Heart": Parenting counter--transference and its neurobiological roots

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Summary

"Impatience of the Heart" ("Beware of pity" in English translation) is a novel by Stefan Zweig about the relationship between an Austrian cavalry officer and a paraplegic Hungarian girl. The officer tries to comfort the girl but his misdirected compassion leads to a tragic result. This paper discusses the instinctive urge to relieve distress (which the author compares to the "parenting response" of the caregiver to an infant) and its potentially harmful manifestations in counter-transference. Such counter-transference and its negative manifestations may not necessarily be an expression of the therapist's unresolved problems, but an over-expression of that innate urge. That urge is not merely a social value, but a part of our mammalian heritage and the author presents evidence from animal studies to that effect. Finally, the author discusses the implication of his conclusions for the training and supervision of psychotherapists.

psychotherapy / counter-transference / compassion / parenting response

"…(compassion) is a double-edged weapon. If you don't know how to handle it you had better not touch it, and above all you must steel your heart against it." [1, p. 241]

"Impatience of the Heart" is a novel by Stefan Zweig (published in English under the title "Beware of Pity"] [1] that tells the story of a relationship between an Austrian cavalry officer and a paraplegic Hungarian girl, set in the days preceding World War I. The two protagonists meet at a party at the girl's home, where the officer unknowingly invites her to a dance. He is shaken by the unintended painful embarrassment caused, returns to apologize, and a friendship between them follows. The kind-hearted, but naïve, cavalryman continues to visit the invalid girl to cheer her, acting out of compassion for her condition and remorse for having caused her pain. The situation gets out of hand, however, when the cavalryman, ignoring the warning of his friend, the wise doctor, about potential "untoward effects" of compassion, succumbs to the success of his efforts, becomes carried away by the dramatic effects of his comforting, and the girl falls passionately in love with him. His fumbling attempts to deal with the situation, the "impatience of the heart", have tragic consequences, demonstrating the destructive potential of misguided compassion.

This misguided attempt by the young officer bears resemblance to the urge on the part of the therapist to relieve a patient's distress and pain. In this paper I wish to discuss that urge, which I refer to as "parenting counter-transference", its potential interference with the therapeutic process, and its presumed biological roots.

It is important, however, to first clarify the meaning of the term "parenting counter-transference" as used in this article. Originally used by Freud to denote an analyst's reaction to a patient's transference (in this case Freud was referring to erotic transference) [2], the concept of counter-transference was gradually expanded to include any emotions, both conscious and unconscious, which the therapeutic relation evokes in the therapist [3, 4].

When discussing counter-transference, several analysts have made the observation that a thera-

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pist may be cast into a parental role, and, therefore, the writers treat this counter-transference (implicitly) as a natural aspect of the analytic situation [5]. The potential for any counter-transference to derail treatment, however, justifies exploring its roots. When counter-transference appears to interfere with treatment, we usually attribute it to emotional problems of the therapist. Money-Kyrle [6] wrote a study of the excesses of "parental" (in his terminology) counter-transference, and attributed it to unresolved unconscious conflicts. According to Money-Kyrle, "Concern for the patient's welfare comes, I think, from the fusion of two other basic drives: the reparative, which counteracts the latent destructiveness in all of us, and the parental. Of course, if too intense, they betray excessive guilt about inadequately sublimated aggressiveness" [6, p. 362]. "Parental counter-transference" as described in psychoanalytic literature, is a broad concept, which refers to assuming responsibility for a patient's life beyond that required by the therapeutic contract. In contrast, the term I suggest, "*parenting* response", is used by infant development investigators to describe the intuitive and innate, "hard-wired" response to an infant which Papousek calls "*intuitive parenting"* [7, 8, 9]. This "hard-wired" response is intended to promote interaction between the infant and his, or her, care-giver; it is initially unconscious and becomes deliberate only after a brief time. It is gradually replaced by a more reflective, conscious understanding of the growing infant's emotional state [10]. The neural substrate of the ability of the parent to recognize and empathize with an infant's emotional state has been the subject of a large body of neuroimaging studies [10]. In conclusion, the study of infant-caregiver interaction validates Papousek's [8] assertion about the innate "hard-wired" nature of the "intuitive parenting".

The urge to relief distress is a cardinal part of "intuitive parenting" and therefore I use the term "*parenting*" to describe that urge. The desire to relieve distress and pain is also a fundamental aspect of the professional ethos of the healing professions, and a conscious, declared part of the therapeutic contract. The motivation to relieve the patient's distress, however, may include more than a conscious commitment to the therapeutic contract, namely an inner pressing *urge,* not necessarily conscious, but powerful nevertheless. This urge is particularly conspicuous when dealing with patients who are victims of gross injustice, victims of abuse or traumatic events, or patients who are particularly helpless and vulnerable, e.g. children. These feelings are familiar to every experienced analyst or therapist and are usually taken for granted, since they are congruent with the therapeutic contract. Nevertheless, it is useful to analyze those feelings because they may exceed the requirements of the situation and interfere with treatment. (Traditional medicine had a term for such an approach: "*furor terapeuticus*".)

A misguided urge to relieve distress and to "resolve" a patient's problems may take different shapes. A therapist might become overprotective thus fostering the patient's dependent or erotic transference. The therapist might also become over-identified with the patient, "fighting his, or her, battles", consciously or unconsciously instigating the patient against his, or her, presumed aggressors, without adequately understanding why the patient did not take such action, and not necessarily acting in the patient's best interests. Other therapists even engage in "patient advocacy", a legitimate intervention in some helping professions but hardly ever in psychoanalysis. Some therapists are drawn into a masochistic submission to the patient, rationalizing it as a wish to avoid frustrating a person who has already suffered so much. Some child therapists, adhering rigidly to the theory of blaming the parents for all of a child's problems (a so-called "nothing but" fallacy), unconsciously encourage a child's opposition to the parents and antagonize them, thus compromising the treatment. A host of counterproductive reactions may appear when the treatment fails to relieve the patient's suffering in reasonable time, or rather, to put it bluntly, fails to relieve the therapist's "parenting" urge (besides the narcissistic frustration). The frustration caused by this situation, the "impatience of the heart", especially when the therapist is not conscious of this frustration, may result in various destructive reactions: subtle aggression or rejection of the patient, projection of blame or avoidance, emotionally distancing oneself from the patient, or even terminating the treatment without justification ("running away" like the protagonist of Zweig's novel).

Some therapists, wisely enough, avoid working with severely traumatized patients, sensing that they could not bear a patient's pain.

There is a suggestive similarity between the reaction of a frustrated therapist and that of parents of a "difficult" child, especially an infant who fails to respond to comforting: some blame anyone that is available, e.g., the other parent; some become "instrumental", going through the motions of soothing the infant while emotionally dissociating themselves from the child's distress; and some become subtly or even overtly aggressive toward the child.

A therapist's unusually powerful need to help has been ascribed to different factors: over-compensation of inadequately neutralized aggression [6]; a projective identification with the helpless victim; a competitive wish to be a better parent than the child's parents have been or are (a wish that may be an extension of a common but usually unconscious desire to be a better parent than our own parents have been); or unconscious feelings of guilt for having been spared the patient's cruel fate, akin to the "survivor's guilt" of combat veterans or people who have lost loved ones in the Holocaust. All of these explanations have merit and apply to many cases of "parenting" counter-transference that may have reached undesirable levels; however, there is another, deeper and unconscious factor behind the compelling the urge to relieve distress, a factor that may "get the better" of a therapist's judgment.

To begin with, we need to recognize that helping the weak and the needy is a hallmark of a civilized society. Civilized societies take pride in such endeavors and instill that value in their young. In other words, the "impatient" therapist errs "by excess of virtue" rather than through a deficiency of personality.

Concern for the weak is called "humanitarian", thus implying that this is a uniquely human, noble feature of the *Homo sapiens* species. Biology proves otherwise: from times immemorial, we have known that female mammals defend their young ferociously as do many birds and some lower vertebrates, namely some species of fish and reptiles. Many female mammals bestow a great deal of attention on their young, licking or grooming them, some teach their young how to hunt or lead them to food. Most mammals display obvious signs of distress when their young ones whine or show other signs of suffering.

Biological investigations [11] demonstrate that nurturing behaviors in mammals are controlled by the same neural and hormonal (i.e., oxytocin and vasopressin) mechanisms underlying reproductive behavior (i.e. vasotocin) in lower vertebrates. Such findings vindicate Freud's assertion that the bond between parents and children derives from the same instinctual source as genital sexuality, an assertion that provoked fierce attacks and is still questioned by uninformed critics. The biological closeness between the roots of compassion and of lust may also be relevant for the observation that sexual attraction easily infiltrates compassionate concern.

Nurturing one's own offspring bestows an obvious evolutional advantage, but helping another adult individual of the same species or even of another species has no such obvious merit; indeed this behavior seems to negate the natural competitiveness among individuals that is seen in most animals. Nevertheless, it is an observable fact. Some, even many, social mammals do show this type of intra-species or inter-species "altruistic" behavior. There is anecdotal evidence, from the days of ancient Greece, of dolphins helping individuals in distress and even of dolphins reportedly saving people from drowning [12] or from sharks [13]. Satiated vampire bats share food with starving companions [14]. Of particular interest are recent experimental studies of empathy in rodents. Mice react more strongly to painful stimuli if they see a cage-mate in pain [15]. Rats placed in a spacious cage learn quickly how to open a small cage in which another rat is confined and distressed. The rats will often choose to open the cage of the other rat before eating a tasty morsel and may even share the morsel with the less fortunate fellow [16]. Therefore, this "altruistic", helping behavior is well documented in several social mammals and is probably present in others.

In conclusion, the urge to relieve suffering, whether in its beneficial or maladaptive expression, is not an invention of civilized society, although a civilized society will cultivate and praise this behavior; rather, it is a part of our mammalian heritage, no less than competitiveness. Therefore, a maladaptive behavior stemming from the desire to help, manifested in ther-

apy as "parenting" counter-transference, is not necessarily an expression of repressed conflicts or wishes (although they may play a role); it is primarily an over-expression of a deep-rooted, biologically determined and culturally reinforced urge, and needs to be recognized and accepted as such. Recognition of the instinctual source of the "parenting" counter-transference places it in the same category as erotic or aggressive counter-transference. There is, however, an important distinction: the latter are clearly contrary to the therapeutic contract and, if acted upon, constitute an infringement of that contract. In contrast, "parenting" counter-transference is congruent with the therapeutic contract and its manifestations, therefore, may be more subtle and less recognizable.

The recognition of an innate "parenting" urge has implications for clinical supervision. A candidate who seems to be experiencing counter-transference problems is often advised by his supervisor to bring them up in his own analysis, or even advised to return to analysis for further clarification of what seems to be an unresolved issue. That advice may need to be qualified when dealing with "parenting" counter-transference. The biological nature of the urge to relieve pain implies that, when dealing with a "parenting" counter-transference problem, one needs to examine not only presumed unconscious dynamic factors, but also consider alternative explanations. These may be related to personality features, such as a therapist's inadequate tolerance of frustration or over-sensitivity to pain. Once the basic innate nature of that urge is recognized, it becomes easier to consciously mitigate its counter-productive manifestation through critical self-observation, as much as the "neurotic" kind of counter-transference is mitigated by dynamic insight.

Footnote: The translator used the word "pity" but I believe the term "compassion" better renders the German "Mitleid" (literally: "suffering together").

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