Rescue Fantasies in the Relational Narratives of Female Psychotherapists

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# Abstract

The current study examines rescue fantasies (RF) in psychotherapy from the therapists’ vantage point. To date, only a few theoretical studies have considered the countertransference of rescue fantasies, and empirical research about the RF of psychotherapists is lacking. In this study, we interviewed 20 female psychotherapists about their relationships with their parents, their own children, and their patients, using the Relationships Anecdotes Paradigm (RAP). We then used the Core Conflictual Relationships Themes (CCRT) method to examine manifestations of rescue wishes in their relational narratives. Based on an analysis of the therapists' propensities towards rescue awareness, as depicted through their interpersonal relational patterns, three types of psychotherapists were identified: (1) *rescuer*, (2) *alienated*, and (3) *dialectic*. An examination of each type demonstrates the dynamics of ongoing interpersonal conflicts involved in the strength and nature of RF. Our analyses show that the therapists' countertransference reactions to the patients that involve rescue are generated by the meeting of origins and triggers. The findings indicate that RF are an inherent thematic component of the therapeutic relationship and a significant factor in the world of therapists. The dominance of the rescue theme and its implications for therapeutic relationships points to the importance of therapists' awareness of their own rescue dynamics and the importance of incorporating this awareness into training and supervision.

*Keywords:* Here

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Rescue, a major theme in stories, legends and myths, involves a triangle consisting of a rescuer, someone who is rescued, and an existential threat, whether real or imagined. In legends, the rescue plot is usually built around brave and courageous knights or princes. These daring and self-sacrificing characters differ completely from the character of the lost, confused, helpless beauty that needs to be rescued. The threat is usually in the form of a terrifying dragon or some other character that is evil incarnate and has nothing in common with the knight. How, then, is this rescue plot relevant to the context of psychotherapy?

The first reference to "rescue" as a psychological construct was made by Freud (‎2002) in the context of his observations of patient fantasies and his theory about the critical impact of the Oedipus complex. Freud describes the wish among certain men to rescue "fallen" women – that is, women of bad sexual repute – and discusses the implications of this wish in regard to relationships and choices. Most early theoretical considerations of this wish viewed RF as a reaction formation to murderous oedipal wishes to kill the father. RF represent an attempt to release this unconscious murderous hostility and to atone for guilty feelings resulting from the wish to destroy the object.

Sterba (1940) was the first to call attention to the aggressive content of RF, along with the life-preserving, love-affirming attitude towards the object to be rescued. According to him, the rescuer must project threatening and hostile content onto the object in order to be able to later rescue it. Subsequent dynamic models claimed that the dynamic source of RF could be found earlier in development (‎Olinick, 1980). The sources of RF can be found not only in the oedipal triangle, but also in the primary ties to the mother and in the experience of loss and repair (Esman, 1987; Lane, 1988; Ross, 1960). For example, deprivation and lack of maternal containment lead to intensifying the fantasy and the search for the masculine rescuer (‎Gerrard, 2007). As a result, the individual is confused between containment and rescue and feels that only if there is rescue can there be containment. In this context, Berman (‎1999) defines the object that needs to be rescued as a vulnerable, denied, and discarded part of the rescuer's personality and the source of danger as a divided and distanced aspect of the rescuer's aggression.

Sándor Ferenczi (‎Berman, 2003a) was the first to draw attention to the therapist in the context of RF, particularly with respect to the idea that countertransference of rescue can shape the patient's transference. Ferenczi described the therapist as someone who unconsciously becomes his patient's patron or knight. However, it took more than 50 years before RF began to be discussed from the perspective of the therapist. Until then, therapists were perceived to be immune from blind spots (‎Berman, 2003b). Greenacre (‎1966) was the first to note that the reciprocal relations between transference and countertransference are related to elements in the therapist's autobiography and choice of profession. When the patient's over-idealization comes into contact with the therapist's unconscious urge for compensation and rectification, the therapist is liable to be motivated by competitive narcissistic drives: on one hand, by a great need to rescue and, on the other hand, by a desire to provide treatment.

The risks inherent in the unconscious need to rescue during therapy are tied to the generation of enactment situations during countertransference, in which the therapist becomes personally invested in the patient's progress. Such enactments can include the following: turning into "addicted" rescuers and exhibiting masochistic behavior in interacting with patients (‎Adler, 1972); developing unconscious resistance to enabling patients to improve and leave therapy (Hammer, 1972); developing negative countertransference in failed therapy or therapy that has reached a dead end (‎Sussman, 1992); developing guilty feelings (e.g. that the therapist is the one who caused or exacerbated the patient's illness) (‎Greenson, 1962); becoming so eager to provide therapy that the psychoanalytic method becomes a burden due to the many demands such as the need to be on target, to perceive rapidly, to communicate compassion, and to rescue (‎Berman, 1993; Fulmer, 2013). A particularly grave situation occurs when, instead of identifying and interpreting signs among their patients of regression to the omnipotent parent, therapists respond using a suffocating approach intended either to satisfy or to frighten the patient. This situation preserves the patient as a helpless child who needs to be held and protected from disaster, thus preventing the patient from taking responsibility (‎Berman, 1993).

The problematic nature of the presence of RF in therapeutic situations with children has been the subject of a separate discussion (Malawista, 2004). These fantasies develop when the therapist attempts to rescue the child who perceived the parent as an "early criminal" (Anastasopoulos & Tasiantis, 1966). When a child therapist sees the parent as repulsive and abusive, and attempts to replace the "bad" parent with the "ideal" parent, the therapist becomes over-identified with the patient and thus loses the ability to relate to the inner sources of the conflict, that is, to the child's share in the problematic relationship.

The relationship between the personal and professional lives of therapists has been a topic of research in the context of understanding the inner world of therapists', and especially in studying countertransference (Hayes, 2004; Hayes & Nelson, 2015; Kissil, Carneiro, & Aponte, 2017). According to Hayes' (2004) pan-theoretical model, the origins of therapists' countertransference are triggered by therapy-related events that touch upon therapists' unresolved conflicts and, subsequently, lead to countertransference reactions. Origins of countertransference are associated primarily with the therapist's family of origin, parenting issues, couple relationships, and unmet personal needs (Sussman, 1992). Referring specifically to RF among therapists-in-training, Slonim and Hodges (2000) argued that training therapeutic interns in early identification of RF helped them to ascertain their patients’ life narrative and contributed to effective therapy. Furthermore, they emphasized that interns had an obligation to their own health and well-being as part of their ethical responsibility. Hence, therapists must pay attention to their interpersonal, emotional, physical and spiritual needs.

**The Present Study**

RF among therapists are inherent to the therapeutic profession and are relevant to therapists across psychotherapy orientations. Our overall goal in the present study was to study the thematic focus of wishes to rescue the other and/or the self, as manifested in interpersonal patterns of female therapists. We examine the therapists' rescue wishes in relation to their parents, their own children and their patients, as expressed in relational narratives collected through Relationship Anecdote Paradigm (RAP) interviews (Barber et al., 1995; Luborsky, 1998; Wiseman & Tishby, 2017). The objective was to examine whether and how the therapists' patterns of relations with their parents and their own children "penetrate" their therapeutic relationships with their patients and serve as a thematic focus involving rescuing the patient (the other) and/or the self. We hypothesized that due to therapists' diverse personal histories, current personal lives (as parents) and professional experiences (as therapists), they will exhibit differing degrees and diverse propensities for rescue themes as well as differing levels of awareness of rescue dynamics in their personal and professional interpersonal relationships.

Because RF are, in most cases, unconscious processes, and because most people have conscious objections to directly reporting these fantasies, RF are difficult to study. To overcome obstacles for directly investigating RF of therapists, we chose to apply the Core Conflictual Relationship Theme (CCRT) method (‎Fried, Luborsky & Crits-Christoph, 1998). The CCRT method is an accepted research tool in psychotherapy for systematic observation and characterization of central interpersonal relationship patterns. This method makes it possible to identify the conflicts and interpersonal relational patterns of individuals (‎Luborsky & Diguer, 1998).

# Methods

## Participants

The sample was comprised of 20 female psychoanalysts. Only women were included in the study to avoid possible gender differences, especially in regard to differences in relationships with their parents and children. The professional background of the participants was diverse: psychologists (n = 9), clinical social workers (n = 2) and expressive art therapists (n = 9). The participants' ages ranged widely, from 28 to 65 years old (*M* = 36), as did their academic education: bachelor's degree (n = 2), master's degree (n = 15), doctorate (n = 3). Nine psychoanalysts had advanced training in individual, couple' and family therapy. Professional experience ranged from 3 to 37 years (*M* = 12).

**Measures**

**Relationships Anecdotes Paradigm (RAP) interview:** The RAP interviews were developed by Luborsky (1998) as a means to elicit relationship narratives in outside-of-therapy settings, thus expanding the opportunities to study narratives. With the RAP interviews, one could study narratives outside of psychotherapy sessions for individuals in psychotherapy (Barber et al., 2002; Connolly et al., 2000; Tishby & Wiseman, 2014; Wiseman & Tishby, 2017), as well in individuals not in psychotherapy (e.g., Raz, Wiseman, & Sharabany, 2007; Waldinger et al., 2002; Wiseman, Metzl, & Barber, 2006). In the RAP interview, interviewees are asked to tell about relational episodes (REs) that took place in their interactions with significant people in their life. The interviewee is asked: “Please tell me some incidents or events, each about an interaction between yourself in relation to another person…” (Luborsky, 1998, p. 110). The accounts have to be about specific incidents, not amalgams of several incidents. For each specific incident, the interviewee is asked to say when it occurred, with whom it occurred, something of what the other person said or did, something of what the interviewee said or did, and what happened in the end. The RAP instructions indicate that the event in the narrative “…has to be about a specific event that was personally important or a problem to you in some way” (Luborsky, 1998, p. 110). Interviewees are usually asked to tell 10 REs and are free to tell any incidents about any person. However, depending on the specific research purpose, the instructions may vary in terms of designating the relationship referent (Wiseman & Tishby, 2017). In the present study, participants were asked to relate 12 interpersonal narratives with the following significant figures: parents (two episodes with the mother and two with the father); own children (four episodes); and patients (four episodes) (Bachar, 2007; Bachar & Wiseman, 2005).

**Core Conflictual Relationships Theme (CCRT).** The CCRT method (Luborsky & Crits-Christoph, 1998) was employed to identify the relational patterns in the relational narratives that were collected in the RAP interviews. The CCRT method is an accepted measure for systematically observing and characterizing central interpersonal patterns from relational narratives. It has been widely used since the mid-1980s in a large number of studies, which determined its reliability and validity for describing central relationship patterns (Fried, Luborsky & Crits-Christoph, 1998; Wiseman & Tishby, 2017). The central pattern of interpersonal relations consists of three CCRT components: (1) *Wish* (W) – what an individual wishes from the other in the relationship; (2) *Response from other* (RO) – the actual or imagined response of the other (or how the other is experienced in responding to the actual or imagined wish); (3) *Response of self* (RS)– the individual's own response in regards to thoughts, emotions, behavior or some other symptom. The recurrent appearances of the specific CCRT components (Ws, ROs, RSs) across relationship narratives serve to form the person’s overall central conflicts and interpersonal patterns. The CCRT method is the first operational measure to assess transference (Luborsky & Crits-Christoph, 1998). A great deal of similarity between patients' relational patterns with their therapists and with significant people in their lives corroborates the utility of the CCRT method in assessing transference (Fried, Luborsky, & Crits-Christoph, ‎1998; Markevitz, 2007). The first study to apply the CCRT method to study countertransference was conducted by Tishby and Vered (2011). The method was tested with 12 therapists treating adolescents. They were asked to relate narratives about their parents and about their clients. The findings showed that all three components of the therapists’ CCRTs with their parents (W, RO, and RS) appeared in their narratives about their clients. In a later study, based on therapists' narratives about their parents and their clients in psychodynamic psychotherapy, Tishby and Wiseman applied the CCRT method as a means for developing a countertransference typology.

**Procedure**

The procedure of the current study that included the RAP interviews, was part of a broader study (Bachar, 2007) that included examining reading responses (Holland, 1975) of psychotherapists to David Grossman's novella "*Her Body Knows*" (Grossman, ‎2003), whose dominant theme focuses on the notion of rescue (Vaknin, 2007). As such, the procedure in this study included three steps in the following order: (1) reading (or re-reading) the novella, "*Her Body Knows,*" immediately before the interview; (2) a semi-structured interview to assess participants' responses to the novella; (3) the RAP interview. Reading the novella indirectly brought up the topic of RF, and participants' responses to the reading were utilized for another part of the study (Vaknin & Dunsky, under review). The interpersonal narratives were collected from the interviewees immediately after the semi-structured interviews, which focused on responses to reading the novella. This order was intended to evoke rescue expressions in the RAP interviews as the participants’ had just shared their subjective responses to the protagonists in the novel in the previous step. However, we note that this order may have colored the relational narratives.

The RAP interview, which included the 12 interpersonal episodes, was audio-recorded and transcribed. The 240 relational narratives (80 on parents, 80 on children and 80 on patients) were rated by two independent judges with clinical experience who had been trained in the CCRT method. Categorical ratings (Barber et al., 1998) served as the basis for an in-depth narrative analysis of the narratives. The analysis focused on tracking repetition of relational themes in the context of rescue in each therapist's relations with her parents and children and in relations with her patients. Meetings were held to increase consent, to minimize biases in interpreting the narratives (in cases where specific categories were rated at a difference of 3 or greater), to formulate the overall relationship pattern, and to identify aspects of rescue that intersected between narratives. After the meetings, the consent between the two judges rose in the W component from 65% to 80%, in the RO component from 80% to 90%, and in the RS component from 75% to 85%. The participants gave their informed consent for audio-recording, transcribing and analyzing the interviews; all identifying materials were removed. Major changes were made in identifying details to preserve anonymity.

# Results

Three types of female psychotherapists were identified: (1) rescuer (n = 5), (2) alienated (n = 4), and (3) dialectic (n= 8). The rest of the interviewees (n = 3) could not be classified into one of the three categories, rather features of all three types appeared in the. Below, we illustrate each of these types with one of the interviewees that depicts that type, and also include features from other interviewees that were classified as that particular type. The detailed narratives that we present were shown to the participants, who again provided their specific consent. Nevertheless, significant editing was done in order to preserve anonymity.

**The Rescuer Type**

We call the first type the ‘rescuer’ type because of the development of strong rescue wishes and a great deal of investment in rescue-related behaviors in relationships with significant figures. This type is generally unaware of the dominance of rescue themes in their life and the implications for interpersonal relations, including those with clients.

In Zehava’s case, a key element of her family history is that she is the daughter of Holocaust survivors. Her parents’ Holocaust trauma and a strong presence of death were consistently present in the home. Zehava is completely consumed with rescuing her vulnerable parents yet does not exhibit awareness of the dominant rescue themes present in her relations with her parents and her children and, in particular, the implications for her relationships with her patients. The content in the majority of Zehava’s interpersonal narratives is related to the powerful experience of “living life in the shadow of death,” which is illustrated through an attachment to the wish or the expectation of rescuing her father. For example, in a narrative in which she shared about a significant interaction with her father, she recalls that he asks her that when she dies, she be buried alongside her family of origin, in the cemetery that is located where her parents live and not, as is customary, in the area where she currently lives. The father’s request is perceived as a firm demand, exemplifying disdain for the family that she has established and the interpersonal connections that she has built in her hometown:

He once said that we would buy graves so that we’ll all be together. I live in a city far away from my parents so I told him that I think that I will be buried in my own city. He said, ‘Who will come to you there? Who will look at you there? Come be buried here next to the whole family.’ It was very important to him, so I said okay, and we also thought about how we would be buried, who will be next to whom? (How did you respond?) What did I feel? I didn’t respond, I was always completely helpless in front of him. To tell him that I have an entire world here? It wouldn’t be convincing. My father was stubborn, a man that you do not disobey, only what he thinks is right. The fact that I said anything at all, it was because I thought to myself, maybe I’ll make a small attempt, so that he can see my world… something like that.

The father’s request represents a complete eradication of Zehava’s world, which is rooted elsewhere. It is possible to interpret the father’s demand as an attempt to remain together, even in death, and to prioritize loyalty to one’s parents in particular, and to the family of origin in general, over loyalty to the family she has established with her husband and kids. The Holocaust survivor father’s wish may be understood in the context of the trauma of separation from his family during the Holocaust (for example, the fact that the father lost his parents in the Holocaust and did not have the option to be buried near his parents since they had no grave). Zehava feebly attempts to argue, out of the wish that her father understand that she has a full, separate world, that she has her own life and interpersonal connections. However, at the same time, she also knows that she won’t hold her own, that her attempt to convince her father is destined to be an absolute failure and that she doesn’t have a choice but to surrender to her father’s desire “to stay together even after death.”

In her additional narratives about her parents, Zehava recognizes her prioritization of her parents’ wishes before her own and her weak attempts to try to confront them. Her reactions are a result of her own desire to protect them and not to make things difficult for them, since death is always in the background. The desire to “save” her parents is manifested through a total loyalty to their ways, acceptance of their demands, and a willingness to please them. The rescue wish is enmeshed with an abandonment of her own self-expression. Within this backdrop of “life in the shadow of death,” arises her desire not to hurt or to cause further suffering, even when it is at the expense of her desire for separation and self-expression.

Death’s prominence continues to have a strong presence in her narratives about her children. In one of the narratives, an expression of the continuous threat of death is used as a justification and legitimization for volunteering her son for a “rescue operation.” Zehava asks her son to write and recite a blessing at the grandfather’s (her father’s) birthday party. The very act of writing the blessing was forced upon the son by his mother, but the son refused to recite the blessing aloud because of the disclosure and embarrassment that would come from reading it aloud:

I told him, ‘But your grandfather is eighty years old, what if he dies next year? What? That’s it, you won’t read him the blessing? It’s irreversible, he’s eighty!’ So he said, ‘It’s hard for me, I’m shy and I don’t want to bare all of my feelings in front of everyone, I can’t!’ I said to him, ‘I don’t care! Get over your fear and read it! Get over it!’ There was also time pressure. We already had a long discussion about it, it was after an entire week of me asking him and his brothers to write a blessing! And they, ugh, they don’t want to, they said leave us alone, and I told them that they have to! Oh…I wanted him to get over the fear and to show responsibility to the family. It’s also the lesson -- to live in the moment, that there’s no tomorrow, there just isn’t! Live life to its fullest! Live life to its fullest. (And what happened in the end?) In the end he read it, he needed a push.

In this narrative, Zehava utilizes arguments such as the grandfather’s advanced age and his impending death to persuade her son, as well as the possibility of a missed opportunity and a lesson on responsibility and family loyalty. The obligation to “live life to its fullest” while in the shadow of death is illustrative of a claim that Zehava is familiar with, to put others’ needs before one’s own, which is repeated here with her son.

We will now present two narratives about Zehava’s patients. The first narrative describes an unusual treatment of a depressed woman, after the death of her young daughter, that takes place in the patient’s home:

The patient did not eat, did not drink, did not sleep, she locked herself in her bedroom and did not leave. It pained the psychiatrist who was treating her to hospitalize her. I volunteered to treat her in her home! I entered her bedroom, and she told me, ‘Leave! I don’t want you here!’ I told her, ‘Your family is in despair, they need you, I won’t leave.’ She said, ‘Fine! If you really want to, but I won’t answer any of your questions.’ I told her, ‘Don’t respond, I will speak.’ She said, ‘Fine, sit!’ She had me sit on a broken chair and I fell. She knew that the chair was broken, and she laughed so much. It was a very difficult treatment. I came to her home for a full year. I would stand on the other side of the door and talk to her and most of the time she did not respond. Every session was a nightmare, but I never forgot, even for one second, that she was a mother that had lost a daughter.

When the story of this patient was shared at a staff meeting, it sparked compassion in Zehava. She volunteered to take on this very difficult treatment, in part to save the patient from being hospitalized. It appears that the RF developed even before meeting the patient. In response to death and grief, a therapeutic relationship ensues that involves abuse and a prolonged rejection of the therapist. The patient does not improve over the course of a year, and the therapist is unable to step out of the ‘rescuer position’ and to re-examine the needs of the patient and the possibilities for additional treatment. The narrative depicts expressions of action and lacks the observational and interpreting stance.

In the second narrative, Zehava talks about another patient in long-term care in which she promises the patient that even after the treatment ends, she will take attend her future wedding, even if it takes place far away:

She called me and asked, ‘You will come to my wedding, right?’ I very much feel that I contributed to her recovery, that I was a part of it. I began a chain of rescuing, I helped those around her to rescue her. She is someone who always crosses boundaries, she always calls me at my home, says that she misses me and wants to have conversations that go beyond the therapy hour. I didn’t tell her that I wouldn’t come to her wedding, I really do think about her, but I do not miss her. I am very happy that she invited me but it’s a hassle, I don’t need it, and I had to tell her that I will not come.

It’s apparent that when the time came, Zehava finds it different to break her promise, despite her desire to do so. During treatment, when her motivation for rescuing was at its peak, she found it difficult to maintain boundaries. She often allowed the therapeutic interactions to go past the therapy hour and made grandiose promises. When her motivation for rescuing decreased (after the treatment ended), the exhaustion or the total commitment of it all, is revealed, as is the difficulty of being in the demanding, long-term rescuer position. When the patient invites her therapist to celebrate her marriage, Zehava desires to end the post-therapeutic relationship, which has become a nuisance.

A wedding invitation from the patient is likely to lead to an open-door policy for every therapist and to pose a dilemma. This narrative, as part of the entirety of Zehava’s narratives, describes the continued pattern in which the wish to rescue is enmeshed with the blurring of boundaries and with the feeling that she needs to abandon her desires for another person’s desires. Zehava demonstrates a strong motivation to rescue, which characterizes the interviewees’ narratives about patients in which they bestow on the patient an abundance of devotion, responsiveness, care, and concern in quantities that cannot be accommodated by the patient. These are exciting, engaging, and ground-breaking treatments that require a lot of dedication. They demand substantial work on the part of the therapist-patient relationship as opposed to just observing and interpreting the relationship.

**The Alienated Type**

We call this type, the ‘alienated’ type, with regards to rescuing because she lacks the inner conviction that there is a prospect of therapeutic change. In this condition -- that of a lack of or a faint desire to rescue -- no feelings of vigor, enthusiasm, challenge, or hope arise from the therapeutic session.

Sara experiences the RF as a piece that is “not-me,” a feeling that undermines her belief that positive possibilities lie within the therapy session. Central to Sara’s model for interpersonal relationships is the theme of lacking control or influence in relationships. The narratives about her parents present a deterministic message, a dominant feature in Sara’s other relationships as well. The narrative about the father involves a recurrent situation from childhood – fights between siblings. Described as a violent pattern of interaction, Sara’s brother suffered (physically) from their father and Sara suffered (physically) from her brother. Sara was not beaten by her father, but she was very fearful of his rage. However, in this narrative, the father deviated from his usual behavior and in the interest of “being fair,” he beat both of his children for being involved in the fight, so as to not discriminate between them:

I remember that, one day, my father did a “fair trial,” because we fought so much that he struck each of us on the hand, a beating like […] I felt scared because, in general, I was terrified of violence, he could be very violent and he was violent, never towards me, only towards my brother. I was immensely fearful that the volcano was starting to erupt and I would try to do all these calming actions, to be very sweet, to appease, to placate, and it doesn’t work for me anymore because it’s already a tragedy for which we know the ending, and someone will get hurt and usually it will be my brother. The time I also got hit, I cried! By the end, I wanted my father to hug me and my brother.

Sara’s experience with her father represented an injustice or wrongdoing, that is to say, it doesn’t matter what you do – you will get the same thing! Sara’s attempts to placate her father, to calm him down from his fit of rage, “to salvage the situation,” were unsuccessful. The consequences of this specific event and additional events in the narratives about her parents, is a feeling of a lack of control over the sequences of events and an overwhelming feeling of guilt. This experience also appears with Sara’s daughter. This type of interaction with a teenage daughter is familiar to every parent when their child is in adolescence, and is illustrated through Sara’s unique portrayal:

A trip with my daughter who is around 14 years old, it was a terrible nightmare, it was exactly at the peak of her disdain for me, in which she is ashamed of me. Whatever I do is wrong […] a feeling that is familiar to me as a daughter myself, very familiar to me and therefore, it is so painful, here it is, it’s happening to me now with my own daughter. I’m really trying to accept it. Sometimes, when we’re alone, I take a deep breath and tell her that it’s hard for me. She doesn’t always know what I’m talking about. I hope and pray in my heart that, nevertheless, something will sink in. I know that it’s like that, that’s adolescence. On one hand, I try not to do it to her, to understand her but, on the other hand, I am very hurt and am pained by it, I go back and forth all the time between these two poles, to take offense or to accept it.

Sara perceives herself as someone who tries very hard to be a different kind of mother than her own parents -- understanding, accepting, exhibiting self-control. But her daughter reacts to her with disdain, is embarrassed of her, and is critical of her. Sara’s main experience is that, even when she tries to do something different, she gets the same reactions of backlash, reluctance, and the familiar feeling of rejection, as she experienced from her parents. Her hope to create a positive influence does not “permeate” the “wall,” this time in her relationship with her daughter. The interaction recreates Sara’s childhood experiences – it doesn’t matter what she does, she will receive the same reactions.

The following narratives illustrates well the “permeability” of this interpersonal pattern of alienation from RF into Sara’s relationship with her patients. The narrative deals with a patient who came to therapy because of her difficulties with creating satisfying and lasting relationships with romantic partners. During the treatment, she meets a partner and excitedly shares with Sara that they are moving in together.

I remember being very reserved and withdrawn, I was unable to be happy, and did not believe that it would actually work out! I would have liked to feel great happiness and contentment. Nevertheless, perhaps I play a part in it? I am going through a very significant and joyful process in the life of a young woman. I want to make a change, but I am not allowing it to happen, I’m not giving it a chance. It happens to me in other situations too, with other people, that I want them to change and then, when they do, I don’t really believe it! I don’t know what it is – not accepting change? Not daring to grow? Not being able to embrace good things? I don’t know what it is. But it is familiar.” What can be construed as a therapeutic success is received by Sara with reservation, and when Sara describes how she feels, she identifies, within herself, an overall difficulty of believing in the possibility of changing for the better.

In another narrative, she describes a patient who is perceived to be easy-going – he shares, goes for the flow and is insightful, however, he is “impenetrable” on the emotional level. Sara indicates that she does not tend to confront patients, rather she waits for things to come up spontaneously during therapy and to be self-initiated by the patient. However, in this case, she decided to deviate from her typical behavior and to confront the patient, “to get real,” so that she can move forward with therapy, which had been at a standstill:

When the patient and I talk, we talk but something on the emotional level does not occur […] This was the first time that I approached a patient with such a direct statement without it spontaneously coming up on its own. It was an experience in which I “got real.” I used the metaphor of the princess and the pea, such that there is another mattress on top of another mattress on top of another mattress, so that, most importantly, you will not feel that pea that’s on the bottom, but the fact is that you do feel it. He told me, ‘Very interesting, maybe it’s not a pea but rather a guava.’

It appears that telling the story about the princess and the pea embodies something of Sara’s relationship experiences in which she feels like the princess in that it doesn’t matter how many mattresses she piles on, she will feel the pea, because people don’t change; hence, the lack of hope for change and improvement. For this reason, one might say that when Sara alienates herself from a vital fantasy that sustains the therapy session, she presents the RF as an aspect of identity that is missing from her professional life, that is absent or has gone awry, along with her feelings of vigor, enthusiasm, challenge, or hope for the therapeutic session. Despair has taken its place. Sara is aware of her alienated stance and asks herself, what is the origin of it? It seems that the answer comes from a retrospective perspective, from her relationship patterns with her parents.

**The Dialectic Type**

We call this type, the ‘dialectic’ type, with regards to rescuing because this type holds a stance of awareness and reflection. In the narratives of dialectic types, although difficult interactions with significant others and patients are described, dispersed throughout are sentences that reflect balanced and realistic points of views of conflictual relationships, portraying an emotional and conscious dialectic.

Dahlia’s next narrative describes an overall feeling of insensitivity from her mother. The aging mother tells Dahlia about her niece’s ‘successful’ partnership and, in the same breath, asks Dahlia about her son, who is not yet in a romantic partnership:

On the phone she tells me about my niece who came to visit her and that she such a lovely boyfriend, almost an accredited lawyer, and he comes from a good family and it was so much fun, and afterwards, I’m ready for when she will ask about my son? And then she really does ask whether my son is in a serious relationship? I feel like throwing the phone, but I keep quiet, and try to finish up the conversation without slamming the phone. She ends the conversation with the phrase “may you experience the same soon.” On one hand, it makes me not want to ever call again. On the other hand, she is over 80 years old, how many more years will she live? To stay stuck in this unbearable circumstance of our impossible relationship? What helps me to approach our next conversation in a more conciliatory manner is that I knew my grandmother, and via intergenerational transmission, my mother inherited bitterness and narrow-mindedness -- this helps me to think about her in a more compassionate way.

Despite the harsh emotions that arise at the sound of her mother’s words, and her desire to sever their relationship, Dahlia manages to regulate and mitigate her anger. Her narrative ends with a more conciliatory concluding sentence about her mother, in which she reveals a deeper understanding of her mother’s motivations and limitations, and of the limited time of their relationship due to her mother’s age.

Additionally, in the narratives about her daughter, we become aware of Dahlia’s abilities to separate her own desires from the developmental needs of her daughter:

When my daughter was on a long trip after the army, she called me more than once in great distress, saying that it’s hard for her and that she is lonely and homesick. At first, I was surprised because she was always so tough, she was in a combat unit in the army, and in the scouts as a child. All of a sudden, I had to say good-bye from the rewarding and empowering image, that my daughter will be able to deal with anything that comes her way. At first, I was frightened, and I wanted to tell her what I really wanted -- come home!! But then I pulled myself together and realized that she needed me to help her to re-gain her strength. After I understood this, what guided me in each of our conversations while she was on the trip was listening to what she needs and not what I wanted. It helped our relationship.

In the narrative, Dahlia describes that she leaves behind the fantasy that her daughter is strong-willed and will be able withstand anything. In the narrative, there is evidence that Dahlia adopts a point of view of awareness and reflection, which simultaneously includes herself and her daughter, and testifies to Dahlia’s ability to abate her own desires and fears in favor of giving her daughter strength and contributing to her daughter’s growth.

In a narrative about a patient, Dahlia describes an internal dialogue that, in this case, concerns a suicidal patient, yet it is presented as central to all of her therapeutic work, beyond any one individual patient. The internal dialogue is characterized as presenting a balanced point of view of her role as a therapist.

Conversations with suicidal patients. She calls and wants to talk only with me, and I completely experience the feeling of, I saved a life right now! Everyone says, ‘Right now!’ Because she called me, she didn’t go through with it! But at the same time, another part of me says, ‘Don’t promise too much, it’s not good, it’s likely to create terrible disappointment and cause hurt.’ My dilemma on this issue is between the feeling of omnipotence, that the therapy session will change everything, and a contrary feeling, that says maybe it’s not possible to help, and if someone gets hurt then we’re done! I feel that I experience this dialogue with almost every patient, sometimes in almost every session.

In Dahlia’s narrative she describes a patient who tells her about touch therapy and that he would like to continue with it, and he is debating whether to stop therapy with her. Dahlia feels that she should take extra precaution when it comes to a treatment that is saturated with sexual tension and a patient who is looking for substantial physical contact:

A very interesting patient, colorful, smart, sensual. There was also a lot of sexual tension in the room. One day he tells me that he is going to do touch therapy. He came with the diagnosis and read it to me. I tried to accommodate, but it seemed unprofessional to me, the entire diagnosis was filled with superlatives about him, it was quite descriptive. He told me that he is debating whether to start treatment there and, in the meantime, to leave our treatment. A lot of thoughts came to my head, the contact was really appealing to him and here, there was no room for something like that. That kind of treatment doesn’t sound serious to me, and I also felt a little hurt that he so easily gives up on treatment with me. In my opinion, we started a significant process, good things had happened in the room and it was not the right time to stop treatment. I told him that I understood that touch therapy was really appealing to him, but maybe he needs to stop for a moment, not make any decisions and, in the meantime, we will examine together why touch therapy is so appealing to him, and why right now, and we will try to bring together everything in the process that we have gone through.

It seems that Dahlia has significant criticisms of the diagnosis summary report and perhaps also of the touch therapy itself. However, she does not confront the patient with her criticisms; rather, she leads him towards uncovering his motivation behind his decision to engage in touch therapy. The obvious thing that she offers is meant to intensify treatment and to introduce the patient to additional elements that have not yet been expressed. The conclusion of this narrative is a specific case that is indicative of all of Dahlia’s narratives. We are presented with “mixed feelings” but, at the same time, they are accompanied by a balanced point of view that includes both advantages and disadvantages, illusion and reality, outrage and sorrow along with appeasement and reconciliation. The relational model embodies a dialectical stance that includes awareness and emotional reflection.

# Discussion

The current study indicates that most of the interviewees indicated RF as a state of consciousness inherent in their professional work and an imminent aspect in defining the goals of psychotherapy. The focal points for an increase in the intensity of the fantasies are related to the transference-countertransference cycle and can be tied to autobiographical elements of the interviewees’ lives.

Analyzing the therapists' narratives about their parents, their children and their patients showed that relational narratives marked by rescue are less coherent and reflective, more self-focused, and incorporate a more obvious repetition of therapists’ relations with their parents, which can be observed in their relations with their own children and patients. In the case of the "rescuer" type, we identified strong rescue wishes and a great deal of investment in rescue-related actions in relationships with significant others. However, we also see that “rescuer” individuals do not have an awareness or a reflective view of the dominance and implications of rescue in their interpersonal relationships, including relationships with their patients. For example, Zehava’s inherent rescue wish involves her renunciation of self-expression aroused in the context of the trauma of the Holocaust. Every time the shadow of death is cast, her wish not to cause her parents any more harm and suffering overcomes her desire for self-expression (for central relationship themes of children of survivors, see Wiseman et al., 2006; Wiseman & Barber, 2008). This theme is repeated in her narratives with her own children, in which she displays a similar renunciation of the self to appease the controlling and, at the same time, vulnerable other. This pattern is also prominent in her interactions with her patients, which reveal her all-encompassing susceptibility to the demands of the others at her own expense, which stems from her rescue wish, of which she has limited awareness. This repetition of perception of the other (RO) with her parents and with her patients (Tishby & Wiseman, 2014) are enacted in the therapeutic relationship (transference-countertransference) involve blind spots that are triggered with her patients (Hayes & Gelso, 2007).

The alienated type with respect to rescue is characterized by a lack of inner conviction of the prospects of therapeutic change. For example, Sara has a more deterministic worldview about her ability to change others' behaviors, which colors her professional work. Sara's interactions with her parents put forth an uncompromising experience: "No matter what you say and no matter what you do, nothing can change your parents." Her experience of having no control or influence over the way she is treated in the relationship constitutes a major aspect of Sarah's interpersonal relational model, which finds expression with her children and her patients. Her interactions with her patients lack even an essential speck of RF.

The dialectic type with respect to rescue is characterized by an awareness and reflective stance. For example, Dahlia describes difficult interactions with her parents and her children; yet, interspersed in her narratives are statements that express a balanced and sober view of these conflictual relations. Her interactions with patients demonstrate a safe and reflective dialogue with the rescue wish. She experiences RF as an inherent motivational aspect in her choice of profession and as a legitimate, relevant and ongoing aspect of self in her professional identity, one that is not meant to be solved "once and for all" during the course of her professional development. On the whole, this relational model embodies an emotional and conscious dialectic.

The narratives support the notion, which serves as the basis of this study, that only a more complete pattern of (early and later) relations with one's parents, one's own children and one’s patients can facilitate an examination of ongoing rescue wishes. The cause of developing problematic communication with patients and/or a problematic desire to rescue is related to the association between the therapist's own unresolved interpersonal conflicts and those of the patient. Therefore, as supported by meta-analytic findings (Hayes, Goldberg, Gelso & Kivlighan, 2018), psychotherapists’ unresolved personal conflicts can give rise to reactions that negatively affect the outcome of therapy, however, successfully managing these reactions seems to be an important element in positive therapy outcomes. Thus, "psychotherapists of all theoretical orientations need to attend to their personal conflicts and monitor their reactions to clients as a routine part of effective clinical practice" (Hayes et al., 2018; p. 496).

Most of the interviewees in the study indicated that RF is a state of consciousness inherent in their professional work and an immanent aspect in defining the goals of psychotherapy. The focal points for an increase in the intensity of the fantasies are related to the transference-countertransference cycle and can be tied to autobiographical elements of the interviewees. Nevertheless, RF should not be seen only in terms of dynamic representations that are disruptive or dangerous; rather, one can view them as facilitating therapeutic work. The structure of rescue consciousness can be seen as constituting a force within the psyche that empowers therapeutic work. Sublimated versions of RF should be differentiated from active versions. In the sublimated version, the behavior of the therapist is not diverted from his/her conscious intentions by an unconscious motivation for rescue. Rather, the therapist is aware of his/her RF, carries out a dialogue with the fantasies and acts to regulate them by outlining realistic help objectives. In contrast, the active version constitutes the realization of unconscious RF in therapy and leads to verbal and behavioral enactments of RF (Grand, 2002; La Farge, 2004).

The findings of the current study contribute to the understanding that sublimated versions of RF serve to establish the therapeutic process both from the motivational aspect of choosing the therapeutic profession (Guy, 1987; Sussman, 1992), as well as the embodiment of the undisputed faith in the positive possibilities inherent in RF. Therapists must be aware of the RFs and have the ability to preserve a dialectic space between fantasy and reality in the context of rescue.. Hence, therapist-patient relations must never be rescue relations, and can only be beneficial when they take place in the dialectic context of rescue. While it can be said that RF are part of the therapeutic process, such fantasies must never be realized. Situations in which the dialectic collapses, narrow and even limits the ability for the therapist and the patient to remain in a space that facilitates a realistic examination of the patient's troubles and that leads to change (Agosta, 2014). Loosening the restrictions of the rescue narrative can encourage a wide range of possibilities for perceiving reality.

These findings reinforce the understanding that aspects that trigger RF must also be examined from the personal perspective of the therapists, within the broader context described by Olinick (‎1980), Goldklank (‎1986) and Sussman (1992) of personal fears, basic unsolved conflicts and the need to rescue oneself as projected onto the other. An understanding of the centrality of the rescue theme in the life of therapists is of critical importance for training and practice; for example, incorporating required reading of literary texts with dominant themes of rescue for interns so as to foster rescue-related dialogue in their own therapy session. In spite of professional development, experience, maturity and ongoing research, rescue remains a dominant theme over the years. This continuity underscores the importance of clarifying and processing RF in training and supervision (Berman, ‎2000). Our argument regarding the risks of the rescuer type (and, to some extent, the alienated type) is supported by a review on the wounded healer (Zerubavel, O’Dougherty, & Wright, 2012), which suggests that the mental health field move towards an approach of greater openness and support for the wounded healer and provides recommendations for cultivating the safe space necessary to promote resilience and posttraumatic growth. Creating safety allows wounded healers to broach and explore issues, which may subsequently help supervisors be better able to assess whether woundedness is negatively impacting clinical work.

The therapist's active participation in the therapeutic process requires taking a major responsibility for her own emotional well-being, as well as development of awareness that the therapist's own reality can invade less conscious regions. Because RF constitute a significant component of the world of therapists, both therapists and the institutions that train them are responsible for clarifying and processing these fantasies, and for converting them from the active to the sublimated version. Only then can RF serve the therapist, rather than create a disservice to the therapist provided by active enactment of rescue fantasies.

The current study suggests that RF transcend work experience, training, and professional orientation. It appears that RF play out in the countertransference reactions of female therapists. A limitation of the study is that we studied only women, and future studies may benefit from examining qualitative differences in RF between female and male therapists. Another direction for future research is to examine RF in personal and professional development (Orlinsky & Ronnestad, 2005; Ronnestad, 2013). In a cross-sectional study, the varieties of initial RF among therapeutic interns and beginning therapists compared to RF among experienced therapists. A longitudinal study could trace continuity and change in the prominence and quality of RF through the course of therapists’ professional development and personal growth. Considering the three the types that we identified, in terms of Orlinsky and Ronnestad's (2013) work involvement, it could be speculated that the rescuer type reflects 'stressful involvement,' the alienated type may reflect a 'distressing practice' and the dialectic type 'healing involvement.'

Finally, as is the case more generally with regard to the inevitability of countertransference, awareness and countertransference management are essential (Gelso & Peres-Rojas, 2017; Hayes, Gelso, Greenberg, & Kivlighan, 2018). We argue that in order for RF not to hinder the therapeutic process, therapists need to be aware of it and take steps to manage it. The tirade of training, personal therapy and supervision (Orlinsky et al., 1999; Wiseman & Shefler, 2001) are important for successful management of RF and for fostering a dialectic stance so that therapists will be able to effectively help patients and alleviate their wounds and pain.

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