ESSENTIAL PAPERS ON COUNTERTRANSFERENCE

Sigmund Freud · Sandor Ferenczi and Otto Rank
Janet MacKenzie Rioch · Theodor Reik
Mabel Blake Cohen · Ralph M. Crowley
Douglass W. Orr · Edward S. Tauber
Clara Thompson · Lucia E. Tower
Heinrich Racker · Harold F. Searles
D. W. Winnicott · Leo Stone · Merton M. Gill
Lawrence Epstein and Arthur H. Feiner

BENJAMIN WOLSTEIN
EDITOR
7. Transference and Countertransference:  
A Historical Survey

Douglass W. Orr

COUNTERTRANSFERENCE: DEFINITIONS

Although the concept of transference, from the point of view of definition, offers some semblance of evolutionary progression to something commanding wide agreement among psychoanalysts, the same cannot be said of countertransference. Definitions of countertransference have varied almost from the first discussions of it, and there remains today widespread disagreement as to what the term comprises. The following can claim to be little more than a catalogue of points of view.

Freud (1910) introduces the term in "The Future Prospects of Psycho-Analytic Therapy":

... We have begun to consider the "counter-transference," which arises in the physician as a result of the patient's influence on his unconscious feelings, and have nearly come to the point of requiring the physician to recognize and overcome this countertransference in himself. ... Anyone who cannot succeed in this self-analysis may without ado regard himself as unable to treat neurotics by analysis [19].

In "Observations on Transference-Love," Freud (1915) says of a patient's tendency to fall in love with successive physicians:

To the physician it represents an invaluable explanation and a useful warning against any tendency to counter-transference which may be lurking in his own mind. He must recognize that the patient's falling in love is induced by the analytic situation and is not to be ascribed to the charms of his person. ... And it is always well to be reminded of this [25, p. 379].

Freud continues, in this paper, to warn against any attempt to influence the transference by partial gratification and then goes on to develop his well-

The first section of this article, which deals with the concept of transference, has been deleted here. The reference for the complete article is: Orr, D. Transference and countertransference: A historical survey. J. Amer. Psychoanal. Assoc., 2: 621–670, 1954.
known dictum that the treatment must be carried through in a "state of abstinence."

On June 3, 1923, at a meeting of the American Psychoanalytic Association, Adolph Stern read one of the first papers—if not the first—dealing extensively with the subject of countertransference which he defines as "the transference that the analyst makes to the patient" (53, p. 167). He continues:

Theoretically, the counter-transference on the part of the analyst has the same origin as the transferences on the part of the patient; namely, in the repressed, infantile material of the analyst. By the same law, it may manifest itself in any form that the transference does. Practically, however, owing to the previous training that the analyst has undergone, his theoretical knowledge and his actual clinical experience reduce considerably the field of activity of the countertransference in comparison with the protean forms which the transference takes in patients [53, pp. 168f.]

Stern also differentiates libidinous from ego components in the countertransferences and illustrates various unanalyzed problems in analysts that may give rise to countertransference difficulties.

Ferenczi and Rank, from whom Stern may well have drawn some of his ideas, add to the definition of countertransference:

The narcissism of the analyst seems suited to create a particularly fruitful source of mistakes; among others the development of a kind of narcissistic countertransference which provokes the person being analyzed into pushing into the foreground certain things which flatter the analyst and, on the other hand, into suppressing remarks and associations of an unpleasant nature in relation to him [14, pp. 41f.].

It will be noted in the references already cited that there is an explicit or implied difference in the concept of countertransference as simply a reaction to the patient's transference as distinguished from the analyst's own transference to the patient for whatever reasons and arising from his own unresolved neurotic difficulties. This distinction becomes a persistent theme in later contributions.

E. Glover (1927) devotes considerable space to the subject of countertransference in his published "Lectures on Technique in Psycho-Analysis" (36, pp. 504–520). He distinguishes positive and negative countertransference as well as countertransference and counterresistance. Both are defined for the most part in terms of reactions to patients' transference reactions, particularly in the transference neurosis, but other determinants in the psychology of the
analyst are referred to. Glover's discussion adds little to the definition of countertransference, but presents a wealth of technical information.

Healy, Bronner, and Bowers (1930) seem to tread warily:

What is spoken of as "counter-transference" must also be reckoned with in connection with the analytic situation. By this is meant impulses on the part of the analyst to respond to the patient's affectional trends. Schilder thinks that there is operative here an important psychological law regulating human relations and that the patient's feelings will of necessity call for complementary ones on the part of the analyst... [37, p. 444].

Reich (1933) does not define countertransference, but he does discuss countertransference problems, and assumes that they arise from the personal difficulties of the analyst (48, pp. 136–140).

Fenichel (1936) notes that little has been written about the important and practical subject of countertransference. Nor does he undertake to define the term. An implied definition is found, however, in the following:

The analyst like the patient can strive for direct satisfactions from the analytic relationship as well as make use of the patient for some piece of "acting out" determined by the analyst's past. Experience shows that the libidinal strivings of the analyst are much less dangerous than his narcissistic needs and defenses against anxieties. Little is said about this subject probably because nothing can act as a protection against such misuse of analysis except the effectiveness of the analyst's own analysis and his honesty with himself [11, p. 73].

English and Pearson (1937) give a diffuse definition of countertransference, but one that is followed by others in the literature: "It is impossible for the physician not to have some attitude toward the patient, and this is called countertransference" (10). In other words, everything that the analyst feels toward his patient is countertransference.

In her book, New Ways in Psychoanalysis, Karen Horney (1939) dealt with the concept of countertransference much as she does with that of transference. She deplores a one-sided preoccupation with infantile conflicts and the compulsive repetition of these in adult life. She says:

The principle that the analyst's emotional reactions should be understood as a "counter-transference" may be objected to on the same grounds as the concept of transference. According to this principle, when an analyst reacts with inner irritation to a patient's tendency to defeat his efforts, he may be identifying the patient with his own father, and thus repeating an infantile situation in which he felt defeated by the father. If, however, the analyst's emotional reactions are understood in the light of his own character structure as it is affected by the patient's actual behavior, it will be seen that
his irritation may have arisen because he has, for example, the fantastic notion that he must be able to cure every case and hence feels it a personal humiliation if he does not succeed . . . [40, p. 166].

Horney appears, here, to define countertransference in terms of the analyst's narcissistic or other neurotic reactions to the "actual behavior" of the patient or to such characterological constellations as neurotic ambition or masochistic dependency. In this she was certainly anticipated by Ferenczi, Stern, E. Glover, and W. Reich, but they did not find it necessary to minimize the importance of unresolved infantile conflicts.

The Balints (1939) examine a hallowed precept: "If and when the analyst has influenced the transference situation by any means other than his interpretations, he has made a grave mistake." They point out that the analyst, in fact, impresses himself upon the patient in countless ways—the nature and arrangement of his office, the hardness or softness of his couch, his way of covering or not covering the pillow, the frequency, timing, affective emphasis, and even diction of his interpretations and, indeed, his whole way of working, some of which in itself is likely to be a carry-over from the transference to his own training analyst—and it is the sum total of these and other, subtle or not so subtle, influences, coloring, if not markedly affecting, the patient's transference, that the Balints call countertransference. They add:

Looked at from this point of view the analytical situation is the result of an interplay between the patient's transferences and the analyst's counter-transference, complicated by the reactions released in each by the other's transference on to him. If this is so—and it really is so—are we to conclude that there is no such thing as the "sterile" method of analyzing? That the opinion quoted at the beginning of this paper is based on an ideal never attained in practice? Formerly belief in the absolute validity of the mirror-like attitude was so firm that contesting it was liable to be regarded as a sign of desertion. And now—not only in the present paper—the very possibility of such an attitude is challenged . . .

The second opinion would lead one to expect that the different analytic atmospheres created by the analyst's personality would exercise a decisive influence upon the actual transference situation and consequently upon the therapeutic results as well. Curiously enough, this does not seem to be so. Our patients, with very few exceptions, are able to adapt themselves to most of these individual atmospheres and to proceed with their own transference, almost undisturbed by the analyst's countertransference. This implies that all of these techniques are good enough to enable patients to build up a transference which is favourable to analytic work . . . We have not forgotten, of course, that our technique has first to comply with the objective demands of our work and naturally cannot be only an outlet for the emotions of the analyst . . . The objective task demands that a patient analysed in any of the many
individual ways shall learn to know his own unconscious mind and not that of his analyst. The subjective task demands that analysing shall not be too heavy an emotional burden, that the individual variety of technique shall procure sufficient emotional outlet for the analyst . . . [5, pp. 228–229].

Sharpe (1947) uses the term countertransference to include both conscious and unconscious reactions of analyst to patient:

"Counter-transference" is often spoken of as if it implied a love-attitude. The counter-transference that is likely to cause trouble is the unconscious one on the analyst's side, whether it be an infantile negative or positive one or both in alternation. The unconscious transference is the infantile one and when unconscious will blind the analyst to the various aspects of the patient's transference. . . . We deceive ourselves if we think we have no countertransference. It is its nature that matters. We can hardly hope to carry on an analysis unless our own counter-transference is healthy, and that healthiness depends upon the nature of satisfactions we obtain from the work, the deep unconscious satisfactions that lie behind the reality ones of earning a living, and the hope of effecting cures [50, p. 4].

Another set of distinctions is suggested by Winnicott (1949):

One could classify counter-transference phenomena thus:

(1) Abnormality in counter-transference feelings, and set relationships and identifications that are under repression in the analyst. The comment on this is that the analyst needs more analysis. . . .

(2) The identifications and tendencies belonging to an analyst's personal experiences and personal development which provide the positive setting for his analytic work and makes his work different in quality from that of any other analyst.

(3) From these two I distinguish the truly objective counter-transference, or if that be difficult, the analyst's love and hate in reaction to the actual personality and behavior of the patient, based on objective observation [55, pp. 69f.].

Winnicott thus subsumes conscious and unconscious, normal and neurotic reactions on the analyst's part under the concept of countertransference.

Berman (1949) distinguishes countertransference from attitudes in the therapeutic process:

In this paper, "countertransference" means the analyst's reactions to the patient as though the patient were an important figure in the analyst's past life. By "attitudes" I mean the emotional reactions of the analyst as a person during the treatment hour, including his reasonable and appropriate emotional responses and his characteristic defenses. It is assumed that the totality of the analyst's emotional reactions, as in all interpersonal relationships, represents a blending, to a varying degree, of appropriate, defensive, and transference responses to the patient, but that the appropriate ones largely predominate [7, p. 159].
Heimann (1950) objects to such distinctions:

For the purpose of this paper I am using the term "counter-transference" to cover all the feelings which the analyst experiences towards his patient.

It may be argued that this use of the term is not correct, and that counter-transference simply means transference on the part of the analyst. However, I would suggest that the prefix "counter" implies additional factors [38, p. 81].

Fromm-Reichmann (1950) summarizes a trend that was given impetus by Harry Stack Sullivan and is seen to some extent also in contributions of Karen Horney, Clara Thompson, and "the Chicago school":

Recently the significant vicissitudes of the psychiatrist's relationship to his patients has been brought increasingly into the focus of therapeutic attention. This holds true for its transferred and for its factual aspects. . . . H. S. Sullivan has introduced the term "paraxis" instead of "transference" and "countertransference." Parataxic interpersonal experiences are distortions in people's present interpersonal relationships. They are conditioned by carryovers of a person's previous interpersonal experiences prevalently from infancy and childhood but not always or necessarily from entanglements with his parents [32, pp. 5–6].

Having mentioned "the Chicago school," I should add, as a matter of interest, that the term countertransference does not appear in the well-known book by Alexander and French (1946). The principle of flexibility advocated by these authors may include control or manipulation of the transference as well as other technical maneuvers designed to effect a "corrective emotional experience." The deliberate assumption of certain attitudes or roles by the therapist might, according to some definitions, be considered "countertransference"—and might actually be caused by countertransference (the unconscious variety) in some instances—but these possibilities are not discussed in the work cited (4).

Annie Reich (1951) excludes the analyst's conscious reactions from her definition of countertransference:

Counter-transference thus comprises the effects of the analyst's own unconscious needs and conflicts on his understanding or technique. In such cases the patient represents for the analyst an object of the past on to whom past feelings and wishes are projected, just as it happens in the patient's transference situation with the analyst. The provoking factor for such an occurrence may be something in the patient's personality or material or something in the analytic situation as such. This is countertransference in the proper sense. . . . [The concept of countertransference may also be understood in a much wider sense to include] all expressions of the analyst's using the analysis for acting-out purposes. We speak of acting out whenever the activity of analysing has an unconscious meaning for the analyst. Then his response to the
patient, frequently his whole handling of the analytic situation, will be motivated by hidden unconscious tendencies. Though the patients in these cases are frequently not real objects to whom something is transferred but only the tools by means of which some needs of the analyst, such as to allay anxiety or to master guilt feelings, are gratified, we have used the term counter-transference. This seemed to us advisable because this type of behavior is so frequently mixed up and fused with the effects of counter-transference proper that it becomes too schematic to keep the two groups apart [47, p. 26].

A. Reich points out further that the phenomena of countertransference proper occur suddenly, under specific circumstances and with certain patients. She therefore calls this "acute countertransference." The other type, representing the expression of a habitual need of the analyst and therefore an aspect of his character, she calls "chronic countertransference." The former, again, is "countertransference proper"; the latter, an "acting-out type of countertransference."

According to Little (1951), the term countertransference is used to mean "any or all of the following":

(a) The analyst’s unconscious attitude to the patient.
(b) Repressed elements, hitherto unanalyzed, in the analyst himself which attach to the patient in the same way as the patient "transfers" to the analyst affects, etc., belonging to his parents or to the objects of his childhood: i.e., the analyst regards the patient (temporarily and varyingly) as he regarded his own parents.
(c) Some specific attitude or mechanism with which the analyst needs the patient’s transference.
(d) The whole of the analyst’s attitudes and behaviour towards his patient. This includes all the others and any conscious attitudes as well [41, p. 32].

Little discusses principally the second of the above:

Repressed counter-transference is a product of the unconscious part of the analyst’s ego, that part which is nearest and most closely belonging to the id and least in contact with reality. It follows from this that the repetition compulsion is readily brought to bear on it; but other ego activities besides repression play a part in its development, of which the synthetic or integrative activity is most important. As I see it, counter-transference is one of those compromise formations in the making of which the ego shows such surprising skill; it is in this respect essentially of the same order as a neurotic symptom, a perversion or a sublimation. In it libidinal gratification is partly forbidden and partly accepted; an element of aggression is woven in with both the gratification and the prohibition, and the distribution of the aggression determines the relative proportions of each. Since counter-transference, like transference, is concerned with another person, the mechanisms of projection and introjection are of special importance [41, p. 33].
Yet another point of view is expressed by Gitelson (1952) who differentiates (1) reactions to the patient as a whole from (2) reactions to partial aspects of the patient. The former are defined as transferences, the latter countertransferences:

It is my impression that total reactions to a patient are transferences of the analyst to his patients and are revivals of ancient transference potentials. These may be manifested in the over-all attitude towards patients as a class or may exacerbate in the "whole response" to particular patients. These attitudes may be positively or negatively toned. They are likely to manifest themselves very early in the contact with a patient and determine the tendency of the analyst towards the whole case. ... Finally, they undermine the possibility of the inner reconstruction that analysis can provide. ...

In contrast to transference, the counter-transferences of the analyst appear later and occur in the context of an established analytic situation. They comprise the analyst's reactions to (1) the patient's transference, (2) the material that the patient brings in, and (3) the reactions of the patient to the analyst as a person. ... [When it happens that the analysis touches on unresolved problems in the analyst,] then we can expect the same type of emergency response as we see in patients when they unexpectedly encounter something new in themselves. ... I think that this means that the analyst remains liable to need to resort to emergency defense reactions and that such reactions are at the center of the analytic phenomenon which we call "counter-transference" [34, pp. 4–6].

Having reviewed most of the pertinent literature, Mabel Cohen (1952) says:

In summary, then, we see that the recent studies on counter-transference have included in their concepts attitudes of the therapist which are both conscious and unconscious; attitudes which are responses both to the real and to the fantasied attributes of the patient; attitudes which are stimulated by unconscious needs of the analyst and attitudes which are stimulated by sudden outbursts of affect on the part of the patient; attitudes which arise from responding to the patient as though he were some previously important person in the analyst's life; and attitudes which do not use the patient as a real object but rather as a tool for the gratification of some unconscious need. This group of responses covers a tremendously wide territory, yet it does not include, of course, all of the analyst's responses to the patient. ... [8, pp. 232ff.].

Cohen asks on what common ground are the above attitudes singled out to be called countertransference? She answers: "It seems to this writer that the common factor in the above responses is the presence of anxiety in the therapist—whether recognized in awareness or defended against and kept out of awareness" (8, p. 235). She then continues by proposing an operational definition as follows:
When, in the patient-analyst relationship, anxiety is aroused in the analyst with the effect that communication between the two is interfered with by some alteration in the analyst’s behavior (verbal or otherwise), then countertransference is present [8, p. 235].

Anxiety-arousing situations, evoking countertransferences thus defined, may be classified as follows:

1. Situational factors—that is, reality factors such as intercurrent events in the analyst’s life; and also, social factors such as need for success and recognition as a competent therapist. 2. Unresolved neurotic problems of the therapist. 3. Communication of the patient’s anxiety to the therapist [8, p. 236].

The most recent contribution to be considered here is that of Fliess (1953) who further delineates the concept of countertransference by distinguishing it from counteridentification. He holds to a traditional view of the former, as follows:

If consistency of designation is required to identify a concept unambiguously, the term “countertransference” must, by virtue of its definition be reserved for the equivalent, in the analyst, of what is termed “transference” in the patient. It is then immediately obvious that countertransference is not, as in transference, an occurrence desirable and prerequisite to the treatment, but undesirable and a hindrance... [15, p. 268].

Fliess points out that countertransference, if its regressive nature is to be understood, will be expected to be in part counteridentification; “it is the clinical coexistence of the two that necessitates their discussion under one title, and that allows one to anticipate... a defective identification behind the defective object relation” (15, p. 279). As for the nature of counteridentification:

The analyst’s faulty involvement with his patients is that found in folie à deux: the identification is mutual, a response of the analyst to the patient’s identifying with him, and repetitive in both patient and analyst of an early “constituent” identification. This term, designed to denote those identifications which the ego does not merely contain but of which it consists, is employed here in order to show that a counter-identification, regressive as it is, interferes with the nonregressive identification, which, as “empathy,” represents a particular phase of the analyst’s work [15, pp. 279f.].

COUNTERTRANSFERENCE: TECHNICAL HANDLING

Discussion of the technical handling of countertransference inevitably varies with differences in definition of the concept itself. Is countertransference
simply the analyst's response to the patient's transference, and does this mean his conscious response, his unconscious response or both? Or does it mean the analyst's transference reactions to the patient, whether to his transference, to other attributes of the patient or to the patient as a whole? Or does countertransference include all attitudes and feelings of the analyst toward the patient whatever they are and whatever may give rise to them? Does it also include attitudes consciously assumed or roles deliberately planned and enacted in order to effect a corrective emotional experience? Does it, indeed, as the Balints suggest, comprise everything the analyst brings to the analytic situation—his office, his technique, and all that he was, is, and ever hopes to be?

Freud (1910) recognizes the patient's influence on the analyst's unconscious feelings, and strongly advises the analyst to recognize and overcome these feelings by extending and deepening his own self-analysis (19). Later, however, Freud (1915) makes passing reference to the fully conscious feelings. Following a discussion of the choices open to the analyst in dealing with the transference love of his patients, Freud concludes: "In my opinion, therefore, it is not permissible to disavow the indifference one has developed by keeping the counter-transference in check" (25, p. 383). And, in a sort of primer of "don't's" for beginners in psychoanalysis, Cole (1922) says:

Don't fail to note signs of a counter transference. These will be found in the analyst's dreams and should be dealt with immediately. A counter transference means the need for further analysis for the analyst. "The analyst can proceed in the analysis only so far as he is analyzed himself" (Freud) [9, p. 44].

Whether he considers it countertransference or not, Freud (1923) notes the importance of the analyst's personality in the therapeutic situation. Speaking of the difficulties of analyzing an unconscious sense of guilt, Freud says:

... Perhaps it may depend, too, on whether the personality of the analyst allows of the patient's putting him in the place of his ego-ideal, and this involves a temptation for the analyst to play the part of prophet, saviour, and redeemer to the patient. Since the rules of analysis are diametrically opposed to the physician's making use of his personality in any such manner, it must be honestly confessed that here we have another limitation to the effectiveness of analysis; after all, analysis does not set out to abolish the possibility of morbid reactions, but to give the patient's ego freedom to choose one way or the other [29, p. 72].

This remarkable passage would appear to state the central issue in much current controversy as to the essential nature of psychoanalysis, especially as to technique!
Stern (1923) takes the traditional view that countertransference interferes with the analytic process:

In the foregoing only the most commonly met with situations likely to give rise to a counter-transference have been considered. True, in some respects the difficulty in the situation may be ascribed to faulty technique. But it was pointed out that the cause of the faulty technique lies frequently in the fact that the analyst, owing to his own resistances, has reacted to the unconsciously determined activities of the patient as if they were consciously determined, and taking place in the present; especially in the fact that the analyst misinterpreted the phenomena of the transference [53, p. 174].

Clearly, the moral is more analysis for the analyst.

As noted above, E. Glover's lectures (1927) contain a wealth of technical suggestions. He points out that even the well-analyzed analyst is by no means invulnerable to the impact of the patient's material, particularly in the transference neurosis; "hence, even if we make the greatest allowance for a hypothetical state of being thoroughly analyzed, it is evident that at least some analytical 'toilet' is a part of the analyst's necessary routine . . . ." (36, p. 507). Glover suggests that the danger signals of countertransference have much in common with the general indications of resistance in any analytic situation, but with distinctive features related to the specialized nature of the analyst's activities. After discussing various technical pitfalls, especially those related to the analyst's narcissistic or sadistic tendencies, Glover adds:

... what distinguishes analytic technique proper from the gratification of unconscious attitudes is its adaptation to the unconscious requirements of the patient. Indications for self-inspection are: that we act always in a stereotyped way or that we cannot immediately justify our interventions or silences on good analytical grounds. We cannot go far wrong if we always know not only why we intervene or are silent, but also what effect we hope to produce by so doing. A third indication is that we cannot explain to ourselves satisfactorily why a patient is still in difficulty. These considerations allow us ample latitude to alter our procedure in difficult or exceptional cases, the criterion being that we are fully aware of the significance of our change in technique and the effects it may produce [36, pp. 513f.].

It is of especial interest that Glover distinguishes and discusses countertransference phenomena and technical difficulties in terms of different stages of ego and libido development, and that he illustrates the insidious as well as the more blatant problems, all of which, as he says, call for eternal vigilance and "that constant attitude of individual watchfulness which we have described as the 'analyst's toilet'" (36, p. 520).

W. Reich (1933) likewise assumes that countertransference difficulties
arise from the personal problems of the analyst, and he mentions particularly those related to the analyst’s repressed aggression, his inability to tolerate the patient’s sexuality, his tendency to experience the patient’s transference narcissistically and his inability to control sadism expressed in the famous “analytic silence” (48, p. 137). He adds, however:

... it is a mistake to interpret the general analytic rule that one has to approach the patient as a blank screen onto which he projects his transfersences in such a manner that one assumes, always and in every case, an unalive, mummy-like attitude. Under such circumstances, few patients can “thaw out,” and this leads to artificial, unanalytic measures. It should be clear that one approaches an aggressive patient unlike a masochistic one, a hyperactive hysteric unlike a depressive one, that one changes one’s attitude to one and the same patient according to the situation, that, in brief, one does not behave neurotically oneself, even though one may have to deal with some neurotic difficulties in oneself.

One cannot give up one’s own individuality, a fact which one will consider in the choice of patients. But one should be able to expect that this individuality is not a disturbing factor and that the training analysis should establish the necessary minimum in plasticity of character [48, p. 139].

Fenichel (1936) agrees with Reich’s last point, noting that the fear of the countertransference may lead an analyst to the suppression of all human freedom in his own reactions to patients. Patients sometimes have the impression, he adds, “that an analyst is a special creation and is not permitted to be human! Just the opposite impression should prevail. The patient should always be able to rely upon the humanness of the analyst. The analyst is no more permitted to isolate analysis from life than is a patient who misuses lying on an analytic couch for the same purpose of isolation” (11, p. 74).

English and Pearson (1937) express in popular terms the prevailing view of the mid-1930’s:

... The good psychotherapist ... is able and willing to conceal any feelings he may have beyond desire to help the patient. Overt pity, sympathy, criticism, intolerance, affection, etc., are best kept out of the attitude of the psychotherapist. His role is to skillfully and tactfully mirror the patient’s emotions and conflicts in such a way that the patient will see their origin and the futility of their endless repetition. The good psychotherapist must necessarily keep out of the therapeutic relationship any personal prejudices he may have upon arbitrary social questions such as divorce, contraception, religious belief. His attitude may be inquiring but impartial ... [10, p. 303].

In a discussion of the contraindication for psychoanalytic treatment, Fenichel (1945) mentions contraindications to analysis with a particular analyst and points out that difficulties in treatment may be due to the analyst. Any
...this difference should never reach a degree at which work with certain personalities becomes entirely impossible. An analyst has to have the width of empathy to work with any type. If the reality in this respect differs too much from the ideal state of affairs, the mistake may be the analyst's; it may be rooted either directly in a negative countertransference or in a disappointment because a certain type of patient does not fulfill some expectation that the analyst unduly and unconsciously connects with his work; in such cases the analyst himself should be analyzed more thoroughly [12, p. 580].

In his book, *Technique of Psychoanalytic Therapy*, Lorand (1946) mentions various countertransference feelings, and then adds: "All such feelings can disturb the treatment unless the analyst is able to refrain from displaying them. Lack of such control is always due to unresolved problems within the unconscious of the analyst" (42, p. 209). He cites Freud's admonitions to this effect and Ferenczi's teaching that one of the most important functions of the analyst is his ability to handle the countertransference. Lorand uses ample clinical material to illustrate two points: (1) that the analyst must be constantly aware of his countertransference, be his feelings friendly or antagonistic, and (2) that the analysis is especially endangered by unrecognized countertransference attitudes (43).

Although Winnicott's article (1949) deals particularly with the treatment of psychotics, the author apparently holds that the same principles may apply in the analysis of others as well. Two passages will illustrate Winnicott's point of view:

I suggest that if an analyst is to analyse psychotics or anti-socials he must be able to be so thoroughly aware of his counter-transference that he can sort out and study his objective reactions to the patient. These will include hate. Counter-transference phenomena will at all times be the important things in the analysis [55, p. 70].

...I believe an analysis is incomplete if even towards the end it has not been possible for the analyst to tell the patient what he, the analyst, did unbeknown for the patient whilst he was ill, in the early stages. Until the interpretation is made the patient is kept to some extent in the position of the infant, one who cannot understand what he owes to his mother [55, p. 74].

During the past ten years the psychoanalytic literature on the subject of countertransference—variously defined—has dealt with several principal themes; some old, some new: (1) the analyst as "mirror" vs. the analyst as "human being"; (2) the question of whether the analyst stays out of the
analysis as much as is humanly possible, except for the work of interpretation, in order to facilitate development of the transference neurosis or whether he intervenes more actively in order to attenuate the transference, to manipulate it or to assume attitudes or play roles designed to provide the patient with a more healthy interpersonal experience than he has known before; and finally (3) when inevitable countertransference feelings or situations develop, whether or not to communicate these to the patient, together with a partial or complete analysis of them in order to mitigate or undo their effects. The technical material of the papers yet to be considered is in some instances so detailed that only the general points of view can be indicated.

Berman (1949) detects a paradox in the writings of Freud and other analysts, and suggests: "The answer could simply be that the analyst is always both the cool detached surgeon-like operator on the patient's psychic tissues, and the warm, human, friendly, helpful physician. I think that such an answer is essentially correct" (7, pp. 160f.). But the matter is not easily disposed of. The problem is:

... how to integrate into the body of psychoanalytic knowledge, theory and technique, the awareness, clinically, that the analytic situation is, in a sense, a personal one for the analyst, and most if not all patients either dimly sense this fact or have occasion to observe it quite directly. It seems to be disturbing to realize and face fully how cathected, and sometimes highly cathected, the patient and his analysis may be for the analyst [7, pp. 160f.].

Berman then describes the dedication that characterizes the attitude of the effective analyst toward his patients, "in the sense of the dedication of the good leader and fond parent that makes an analyst's attitudes of kindly acceptance, patience and so on, genuine and effective" (7, p. 161). Berman believes that much of therapeutic value comes from the patient's testing of the analyst, provided that the analyst handles himself well:

In brief, I think it is in the patient's experience of the process through which the analyst under stress achieves realistic and well-integrated functioning that an important therapeutic factor is to be found. The sound functioning the analyst has found prior to his work with a given patient may not ring very true to this patient until he has, to refer again to the military analogy, exposed the analyst to a fresh baptism of fire [7, pp. 162f.]. [Finally] In regard to the technical question of how open and truthful the analyst should be about his various feelings toward the patient in order to provide the emotional experience the patient requires, it seems that the verbal expression of such feelings is needed only infrequently and to a limited extent [7, p. 165]. [In dealing with certain defenses, however,...] it may be necessary for the analyst to express himself verbally as to his feelings toward the patient [7, p. 165].
Paula Heimann (1950) summarizes her position as follows:

In my view Freud's demand that the analyst must "recognize and master" his counter-transference does not lead to the conclusion that the counter-transference is a disturbing factor and that the analyst must become unfeeling and detached, but that he must use his emotional response as a key to the patient's unconscious. This will protect him from entering as a co-actor on the scene which the patient re-enacts in the analytic relationship and from exploiting it for his own needs. At the same time he will find ample stimulus for taking himself to task again and again and for continuing the analysis of his own problems. This, however, is his private affair, and I do not consider it right for the analyst to communicate his feelings to his patient. In my view such honesty is more in the nature of a confession and a burden to the patient. In any case it leads away from the analysis. The emotions roused in the analyst will be of value to his patient, if used as one more source of insight into the patient's unconscious conflicts and defenses; and when these are interpreted and worked through, the enduring changes in the patient's ego include the strengthening of his reality sense so that he sees his analyst as a human being, not a god or a demon, and the "human" relationship in the analytic situation follows without the analyst's having recourse to extra-analytic means [38, pp. 83–84].

Fromm-Reichmann (1950) also stresses the importance of the therapist's self-awareness:

... Every psychiatrist now knows that there must be a fluctuating interplay between doctor and patient. This inevitably follows from the interpersonal character of the psychotherapeutic process. The psychiatrist who is trained in the observation and inner realization of his reactions to patient's manifestations can frequently utilize these reactions as a helpful instrument in understanding otherwise hidden implications in patient's communications. Thus the therapist's share in the reciprocal transference reactions of doctor and patient in the wider sense of the term may furnish an important guide in conducting the psychotherapeutic process [32, pp. 5–6].

Few analysts are as forthright as Little (1951) in advocating interpretation of the countertransference to the patient. This is important, she believes, to correct the impact of mistaken or mistimed interpretations (caused by countertransference) and in order to permit the patient to express his anger. She says:

Not only should the mistake be admitted (and the patient is entitled not only to express his own anger but also to some expression of regret from the analyst for its occurrence, quite as much as for the occurrence of a mistake in the amount of his account or the time of his appointment), but its origin in the unconscious counter-transference may be explained, unless there is some definite contra-indication for so doing, in which case it should be postponed until a suitable time comes, as it surely will. Such explanation may be essential for the further progress of the analysis, and it will have
only beneficial results. . . . Only harm can come from the withholding of such an interpretation.

Let me make it clear that I do not mean that I think counter-transference interpretations should be unloaded injudiciously or without consideration on the heads of hapless patients, any more than transference interpretations are given without thought today. I mean that they should neither be positively avoided nor perhaps restricted to feelings which are justified or objective. . . . (And of course they cannot be given unless something of the counter-transference has become conscious.) The subjectivity of the feelings needs to be shown to the patient, though their actual origin need not be gone into (there should not be "confessions"); it should be enough to point out one's own need to analyze them; but above all the important thing is that they should be recognized by both analyst and patient [41, p. 37].

Gitelson (1950) completed his paper before he read the one by Little (41), but in a postscript he expresses his essential agreement with her. He says:

Counter-transferences thus constitute an accidental casting of the analyst in an intrusive part in the psycho-analytic drama. Through the analysis of the counter-transference the analyst can re-integrate his position as an analyst and regain a position from which he can use the interfering factor for the purpose of analysing the patient's exploitation of it. In some instances this may mean a degree of self-revelation (by which I do not mean confession). But in a going analysis it may be found possible. In such a situation one can reveal as much of oneself as is needed to foster and support the patient's discovery of the reality of the actual interpersonal situation as contrasted with the transference-counter-transference situation [34, p. 7].

In volume I of The Annual Survey of Psychoanalysis (33), M. Balint and Tarachow epitomize two articles, apparently unrelated, that approach the problem of countertransference, albeit from different directions. The first is Oberndorff's "Unsatisfactory Results of Psychoanalytic Therapy" in which the author advocates discussion with colleagues in unsatisfactory cases and expresses the conviction that faulty countertransference reactions will be uncovered in many such situations. It is his impression that analyst and patient seduce each other into interminable analysis such that everything is analyzed but nothing changes. Too great preoccupation with the past may result in neglect of current disturbing realities and—one should add—of the transference, a point that Ferenczi and Rank (14, p. 37) made thirty years ago.

The second article is Grotjahn's "About the 'Third Ear' in Psychoanalysis," a critical review of Reik's Listening With the Third Ear. Of this, Balint and Tarachow observe: "Reik's approach to the countertransference problem is an autobiographic one. To him the analyst's willingness to trust his own passively arrived at perceptions of the patient's unconscious, constitutes the
core of sound analytic technique”’ (33, p. 239). Balint and Tarachow believe that these two articles represent a trend:

On the whole, one gets the impression that psychoanalytic technique is entering a new phase, rather reluctantly, to be sure. The preceding phase was chiefly concerned with the analysis of the transference, i.e., the patient’s contribution; the new one, if we are right, will aim at the countertransference, the analyst’s contribution [33, p. 240].

Mabel Cohen (1952) stresses the virtue of constant self-awareness on the part of the analyst, but she is conservative in the matter of interpretation of the countertransference. She states her position as follows:

It will be noted that the focus of attention of these remarks is on the analyst’s own self-scrutiny, both of his responses to the patient’s behavior and of his defensive attitudes and actions. Much has been said by others (Heimann, Little, Gitelson) regarding the pros and cons of introducing discussion of countertransference material into the analytic situation itself. That, however, is a question which, in my opinion, it is not possible to answer in the present state of our knowledge. . . . It would seem more feasible to devise techniques for utilizing such material in the therapeutic situation after the area has been more precisely explored and studied—or, rather, concurrently with further study and exploration [8, p. 242].

As noted above, Fliess (1953) defines countertransference as the equivalent, in the analyst, of the patient’s transference. He adds:

The technique to abolish it becomes evident if the aforementioned definition is kept in mind. Transference, we have been taught by Freud, must be analyzed when it has become, or is about to become, a resistance; countertransference, always resistance, must always be analyzed. . . . If the analyst has, as he should, become aware of a countertransference phenomenon before the patient has done so, he will perform all or most of this self-analysis outside of the analytic hour. If the analyst has produced a symptom of countertransference, of which the patient, without recognizing it as such, is naturally aware, part of the self-analysis may have to be communicated to the patient [15, pp. 268–269].

SUMMARY

It is difficult to summarize an article that is itself a summary. I have attempted to review historically the psychoanalytic concepts of transference and countertransference from two points of view: (1) definition and meaning as psychological phenomena, particularly as encountered in psychoanalytic therapy; and (2) technical handling during the process of psychoanalytic treatment. I did not undertake to discuss other aspects of psychoanalytic
technique or to deal with the related and tremendously important subject of theory of neurosis. It would appear, however, that further clarification of the concepts of transference and countertransference as well as of other issues of psychoanalytic technique must await a better integration of ego psychology, and particularly more definitive knowledge of early ego development, into psychoanalytic psychology and theory of neurosis. There is almost universal agreement on the crucial importance of transference and countertransference in clinical psychoanalysis, but far from unanimous agreement on how these concepts are to be understood and still less on how the phenomena themselves are to be dealt with in psychoanalytic treatment.

BIBLIOGRAPHY

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